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# THE JOURNAL

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JANUARY, 1954

NUMBER 1

### PULMONARY CHANGES SECONDARY TO CARDIOSPASM

RALPH C. WILMORE, M.D.

*Indianapolis*

**A**LTHOUGH RESPIRATORY SYMPTOMS have been recognized in association with cardiospasm for more than a century, only a few scattered reports appeared in the literature prior to 1944. Aspiration of the contents of the dilated esophagus causes pulmonary disease in a significant number of instances. It is the purpose of this report to reemphasize the importance of considering cardiospasm in the etiology of pulmonary disease.

In reviewing the literature on this subject, 137 cases with x-ray findings of pulmonary disease complicating cardiospasm were found. Weens<sup>1</sup> in 1944 reviewed the literature and added five cases of his own. In 1949, Belcher<sup>2</sup> collected 29 cases from the literature and added five new ones. An excellent and complete review of the literature was made in 1951 by Breakey, Dotter, and Steinberg<sup>3</sup>. They found 46 cases reported prior to that time and added 17 of their own. Also in 1951, Lake<sup>4</sup> added five cases to the mounting number. Added to this was the series of Andersen, Olsen and Holman<sup>5</sup> who found 63 cases of pulmonary complications in 601 cases of



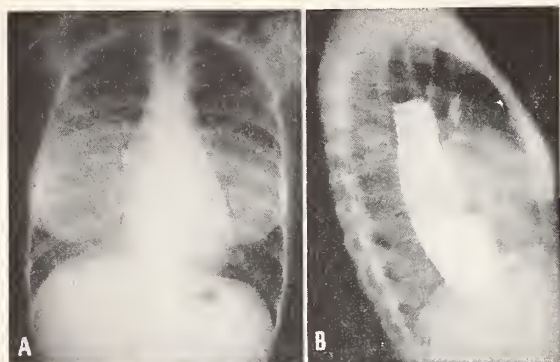
Ralph C. Wilmore, M.D., specializes in internal medicine and is assistant professor of medicine at the Indiana University School of Medicine. He is an alumnus of that school having received his degree in medicine from I. U. in 1939.

cardiospasm at the Mayo Clinic. There have been two recent isolated cases reported, one by Kenny<sup>6</sup> and one by Helm<sup>7</sup>. Four cases are being added in this report.

#### CASE REPORTS

**CASE 1. M.S.** A 34-year old housewife was admitted to the hospital in 1951 complaining of weakness, a productive cough and moderate exertional dyspnea. In 1946, during a pregnancy, a chest x-ray had shown an infiltration in the lungs. She had failed to heed the advice of her physician to return after delivery to investigate

Fig. 1 (Case 1)



A. Bilateral fibrosis.  
B. Dilated esophagus.

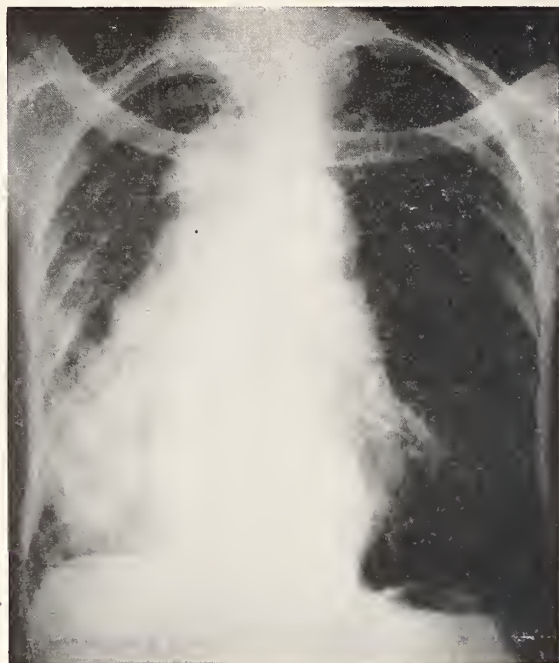
the pulmonary disease. However, she consulted a doctor in 1950 because of severe fatigue, weakness and a cough, productive of small quantities of yellowish white sputum. Because of the x-ray findings and clinical symptoms, she received streptomycin for a short time as therapy for suspected pulmonary tuberculosis. After referral to another physician, sputum cultures revealed *candida albicans*. She was treated with a vaccine prepared from the sputum.

Physical examination on admission revealed a small poorly nourished woman appearing older than stated age. The only positive findings were a few scattered crackling rales in the base of the right lung posteriorly and clubbing of the fingers and toes. Careful questioning, after observing the fluid level in the esophagus on a plain chest x-ray, brought out the fact that she had had difficulty in swallowing since 1940. X-rays showed bilateral pulmonary fibrosis (Fig. 1 A) and a dilated esophagus (Fig. 1 B). Dilatation with bougies at intervals improved the symptoms of the cardiospasm.

This case represents the most common type of pulmonary complication of cardiospasm—non-specific fibrosis. *Monilia* are frequently found in oral secretions and also as secondary invaders in chronic pulmonary disease. It was not considered significant in this case.

**Case 2. S.T.** A 72-year old housewife entered the hospital in 1950 with the complaint of difficulty in swallowing for several years. The dysphagia had been very severe for one month. There had also been some dyspnea during the month before admission. Physical examination revealed an emaciated woman with no other significant findings. X-ray showed cardiospasm

Fig. 2 (Case 2)

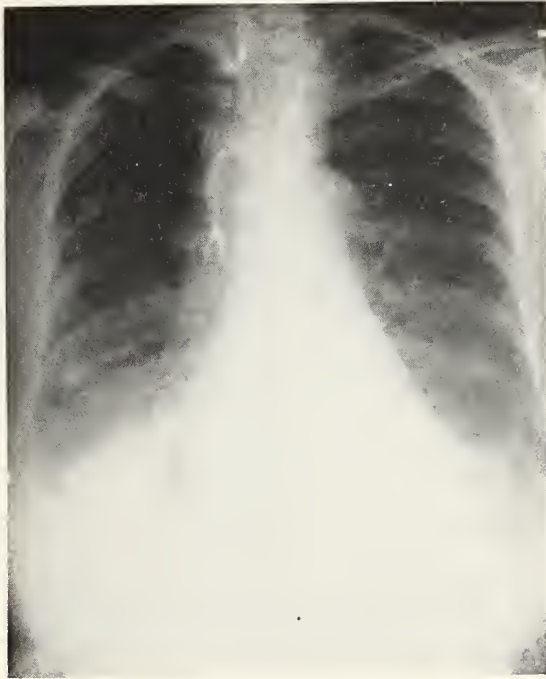


with infiltrative density in the right lung suggestive of pneumonitis, also diminution in the capacity of the lower right chest suggesting partial atelectasis. (Fig. 2). In spite of a feeding gastrostomy, the patient had a downhill course to death. Autopsy revealed cardiospasm and partial atelectasis of the lower lobe of the right lung. Both lower lobes were the site of pneumonitis. This case represents two of the complications (atelectasis and pneumonitis), of long standing cardiospasm. However, it could be said that the pneumonia was a terminal hypostatic affair.

**Case 3.** A 63-year old housewife entered the hospital in 1950 with the complaint of difficulty in swallowing for 30 years. The dysphagia and regurgitation had become progressively worse during the two years before admission. There were no positive physical findings on examination. X-ray revealed cardiospasm and confluent parenchymal densities in both lung bases. (Fig. 3). There was improvement in swallowing following esophageal dilatation. This also represents nonspecific fibrosis in long-standing cardiospasm.

**Case 4. H.S.** A 6½-year old girl was admitted to the hospital in 1951 with the complaint of difficulty in swallowing. The dysphagia had been present intermittently since approximately 7 months of age. Esophageal dilatations had

Fig. 3 (Case 3)



bronchiectasis of lower and middle lobes of right lung (Fig. 5B). An esophagogastrostomy was performed. Since this, she has had no difficulty eating. There have been few symptoms of bronchiectasis.

This case is an example of bronchiectasis developing as a complication of cardiospasm. This child is known definitely to have had cardiospasm for five years by x-ray, and probably longer by history. However, the pulmonary symptoms became manifest only one year prior to admission.

## DISCUSSION

The incidence of pulmonary disease as a complication of cardiospasm is probably greater than is generally suspected. Many large series of cases of cardiospasm are reported with little mention of pulmonary symptoms or roentgenological pulmonary findings. Of the 40 recorded cases of cardiospasm at Indiana University Medical Center in the last ten years, four showed definite x-ray findings of pulmonary involvement. Andersen, Olsen, and Holman also found a 10% incidence in their 601 cases of cardiospasm. Lake reported a 4% incidence in 124 cases of cardiospasm. There is no sex predominance, and it may occur at any age.

Either massive aspiration or repeated aspiration of small amounts of esophageal contents may cause pulmonary involvement. This aspiration would tend to occur more commonly at night when the cough reflex is normally somewhat depressed, and when the patient is in the recumbent position.

The initial complaints in the majority of cases reported are referable to cardiospasm. However, a significant number may have pulmonary symp-

helped for a time on two or three occasions. There had been repeated "chest colds" during the year before admission with fever and productive cough. Physical examination revealed a somewhat undernourished girl with diminished breath sounds over the right lower chest posteriorly. X-rays showed a dilated esophagus (Fig. 4), and increased markings in the lower lobe of the right lung (Fig. 5A). Bronchograms showed

Fig. 4 (Case 4) Dilated esophagus.

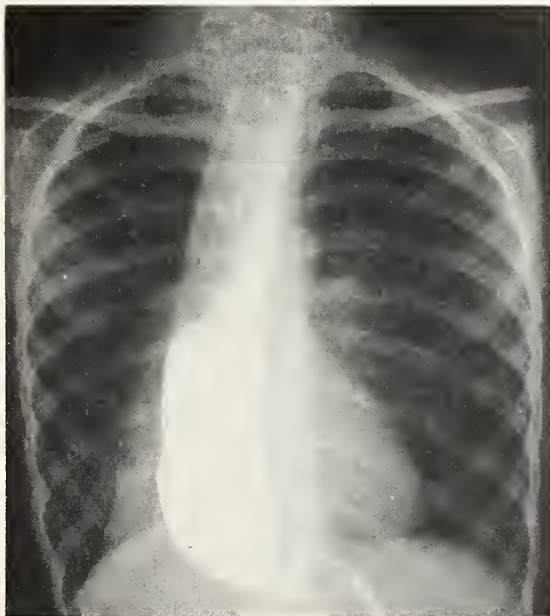
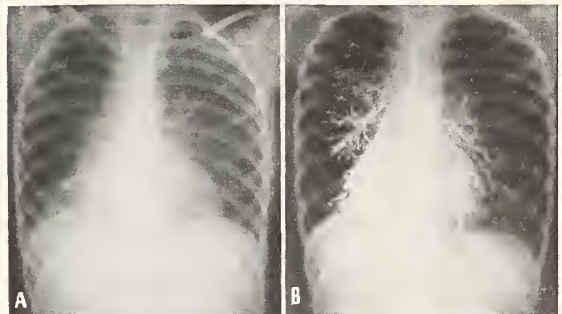


Fig. 5 (Case 4)



A. Increased markings right lower lobe.  
B. Bronchogram.



toms as presenting complaints. This was true in more than one-third of the cases reviewed by Breakey, Dotter and Steinberg. Pulmonary symptoms of this condition include cough, either productive or non-productive, dyspnea, hemoptysis, fever and chest pain.

Nonspecific infiltration or fibrosis was the commonest type of pulmonary complication encountered in cardiospasm. This was true in 28 of Breakey et al's series of 63 cases. However, the incidence of the types of complications was changed when Andersen et al's series was published. Forty-six of their 63 cases were called aspiration pneumonitis. Hurst<sup>8</sup> has reported a death due to asphyxia resulting from a massive aspiration. The summary of the pulmonary complications of cardiospasm in the cases reported in the literature plus our own is shown in the table.

TABLE I. PULMONARY COMPLICATIONS

Type	No.	Percentage
Non-specific infiltration or fibrosis--	33	24.1
Pneumonia -----	57	41.7
Lung abscess -----	11	8.0
Pulmonary tuberculosis -----	10	7.3
Bronchiectasis -----	11	8.0
Atelectasis -----	4	2.9
Oil-aspiration pneumonia -----	3	2.2
Pleural effusion -----	3	2.2
Occlusion of bronchi with asphyxia -	1	0.7
Pneumothorax -----	1	0.7
Asthma -----	1	0.7
Emphysema -----	2	1.5
Totals	137	100.0

Tuberculosis may be a complication of cardiospasm. There were five such cases included in the review by Breakey et al. However, another consideration is that cardiospasm could certainly exert an aggravating influence upon already present pulmonary tuberculosis. Repeated aspiration of esophageal contents would have a deleterious effect upon this condition. Also, the pulmonary infiltration caused by aspiration may be mistakenly considered tuberculosis, as was our first case for a short time. Some of these people with cardiospasm and associated pulmonary disease have spent time in sanatoriums before the correct diagnosis has been made. This is readily understandable because non-tuberculous acid fast organisms are many times found in the esophageal contents and in the sputum in dysphagia

pneumonitis. Thus, the importance of getting cultures of these organisms and not relying upon the mere finding of acid fast organisms in the sputum is evident.

Since the aspiration in cardiospasm apparently occurs at night when the cough reflex is dulled by sleep, it seems logical that the right lung should be involved most frequently. The right main stem bronchus assumes a quite vulnerable position when the body is supine.<sup>9</sup> In slightly more than 50% of the cases the right lung alone was involved. Bilateral involvement occurred in about 30% of the reported cases. The left lung alone was involved in only a small percentage of cases (less than 10%). In slightly more than 10% of the reported cases, the site of involvement was not mentioned.

It is important to consider the problem of pulmonary complications of cardiospasm for more than one reason. First, this condition should be considered as a possible cause of any obscure pulmonary disease. The etiology of pneumonitis, pulmonary fibrosis, and lung abscess is often difficult to determine. These are the first three in order of incidence of the pulmonary complications of cardiospasm. A barium swallow may settle this problem on occasion. This may be especially true when a patient fails to give the entire history as in our Case 1. On the other hand, therapy may be unsatisfactory in any of these conditions as long as the cardiospasm continues untreated. Hence, it becomes important to recognize cardiospasm as the cause of these pulmonary conditions not only for diagnostic purposes, but also for therapeutic reasons.

Treatment of these pulmonary conditions is the same as in the absence of cardiospasm. But the recurrence or progression of the condition may be prevented by treating the cardiospasm. Of course, pulmonary fibrosis of the extent of Case 1 is not reversible.

SUMMARY

1. A brief review of the literature on the pulmonary complications of cardiospasm is presented.
2. Four additional cases are reported bringing the total of case reports to 137.
3. A discussion of the incidence, pathogenesis,

symptoms, and type and location of the pulmonary complications is presented.

4. The importance of considering cardiospasm as an etiological factor in obscure pulmonary disease is stressed.

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#### THE CLINICAL USE OF DIGITALIS PREPARATIONS

The authors are convinced that the present emphasis on salt-depleting programs in the management of congestive failure ignores the primary indication for digitalis in this condition. They believe in accordance with present accepted principles that the fluid disturbance in congestive failure is a result of altered renal function which in turn follows the inadequate cardiac output implicit in the term, heart failure. Consistent with this thinking they insist that primary treatment should be improvement in the heart output best accomplished by digitalization, and that the removal of accumulated fluid is merely symptomatic therapy. They caution that the loss of accumulated fluid achieved by digitalis is not associated with a fall in serum sodium, whereas the low-salt diet and to a much greater degree, the mercurial diuretics, while removing additional fluid carry a threat of dangerous hyponatremia. They believe that any patient who fails to stay compensated on digitalis should have a trial of increased dosage of digitalis before resorting to mercurials, and suggest the rapidly excreted drug Digoxin might be added to whatever form of digitalis has been used in checking the need for additional digitalis. The various common digitalis preparations are very adequately reviewed as to dose, timing of action, and rate of excretion.

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The Clinical Use of Digitalis Preparations in Congestive Heart Failure: Porter, R. R., M.D., and Beckwith, R. P. M.D., Richmond, Virginia.  
*Va. Med. Monthly*—Vol. 80 p. 610 November '53.

## PROLONGED LABOR\*

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**S**PEAKING in a light vein, one might exclaim, "Oh, what a joy obstetrics would be were it not for prolonged labor!" However, soberly, we would reflect, "Without prolonged labor, there would be but little need for us obstetricians."

Prolonged labor is an onerous experience for the patient, the family, and the doctor, and is characterized by an anxiety shared by all three. However, regardless of *their* plight, the chief brunt falls upon the baby. Fetal death from asphyxia is approximately 5 times, and from intracranial hemorrhage  $2\frac{1}{2}$  times, that in normal labor. These figures do not measure the increased number of those that survive with permanent damage.

When we endeavor to define prolonged labor, we find ourselves quite stymied, in that the accepted time element by various clinics ranges from 18 to 48 hours. At our clinic at Indiana University, the usual maximum is 30 hours. Improved technics, the advent of "miracle drugs," and blood transfusion have encouraged the extension of hours. It can be aptly stated a patient should not be allowed to labor over 12 hours without cervical dilation and effacement and advancement of the presenting part, unless the situation is otherwise evaluated by a sterile vaginal examination.

In dealing with cases of prolonged labor, the single outstanding criterion is the effect of the so-called "trial labor," often spoken of as the "test of labor." Here, again, we find ourselves on somewhat confusing grounds. The definition of trial labor varies from the old, hard, arbitrary elucidation, "One to two hours of strong pains after the cervix has become fully dilated and the membranes have ruptured," to that of intelligent clinical observation as to the progress made in dilation, favorability, and effacement of the cervix, the descent of the presenting part, the



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status of the fetal heart and the mother's condition. In other words, *intelligent* rather than *watchful* waiting is the word of the day. From this, a decision is made usually within 12 hours as to whether vaginal delivery may be safely anticipated for both the mother and the child. Fortunately, the procedure as described in the first definition has been outmoded by better obstetrics. The lives and welfare of both the mother and infant are jeopardized not only in the prolonged second stage of labor, but in the first stage as well. In all cases of prolonged labor, our guiding observation in terms of the mother should be "What can the patient accomplish, rather than what can she endure." And as to the baby, "How can we spare it distress, rather than, how much abuse should we allow it to tolerate."

The three factors that most commonly affect the test of labor, either favorably or unfavorably, are cephalopelvic disproportion, abnormal presentations and positions, and uterine inertia. Among the less frequent and, for the most part less serious factors, are unruptured membranes, cervical dystocia, tumor obstruction, elderly primiparity, and the pathological retraction ring.

### Cephalopelvic Disproportion

Except for the external obstetric conjugate and the transverse outlet diameters, external

\* Presented before a discussion group at the American Academy of Obstetrics and Gynecology meeting in Chicago December 16, 1952.



pelvimetry has become passé. Although, the external conjugate (Baudelocque diameter) is not completely reliable, if under 18 cm., it frequently affords important information when screening for pelvic contraction. When this diameter is less than 18 cm., x-ray investigation is strongly indicated, because nearly 50 percent of such cases experience difficult deliveries. This fact would emphasize the importance of taking this diameter on every obstetric case.

The bi-ischial or transverse outlet diameter in most hands can be measured more accurately clinically than by x-ray. Since 34 percent of pelves show a shortening of this diameter, the need for its routine measurement cannot be refuted. This importance is further demonstrated by the fact that outlet contraction usually indicates midplane contraction, again warranting further scrutiny of the pelvic interior.

If one is aware of outlet contraction in advance of delivery not only can he predict a protracted labor, but he may forego a median episiotomy, a breech extraction, an internal podalic version, and an attempted Scanzoni maneuver. Of course, in evaluating the outlet, he will take into consideration the compensation of the posterior sagittal diameter.

The diameters most involved in the birth of a baby are those of the pelvic cavity. It is here x-ray pelvimetry is of greatest use in that it affords not only the only means of ascertaining accurate measurements, but discloses such mid-pelvic and low pelvic contractions as sacral variations, side wall convergence, prominent spines, acute sub-pubic angle, and narrow sciatic notch.

The importance of these various encroachments upon the birth passage in relation to protracted labor has so stimulated the advancement and use of pelvioradiography that many modern authorities have discarded external pelvimetry altogether, and are recommending routine x-ray investigation in all primipara and in those multipara having a history of difficult labor. In other words, a knowledge of the pelvic architecture and the available capacity is considered paramount. Such an investigation includes both anteroposterior and lateral roentgenograms. From such study, some valuable deductions have been made: e.g.—

1. If the C.V. (conjugate vera) plus the transverse of the inlet equals 20 cm. or less,

unless dealing with a premature fetus, cesarean section *without* trial labor is indicated.

2. Because of mutual compensation, the sum of the anteroposterior and transverse diameters of any given plane is a more reliable index than either considered separately.
3. As a rule, the inlet and midplane tend to vary together.
4. With an adequate transverse diameter in any plane, there is seldom dystocia at that level.
5. There can be no serious outlet contraction without commensurate contraction of the midplane. In other words, outlet contraction in most cases, is actually midplane contraction.
6. The average product of the anteroposterior and transverse diameters of the normal inlet is 145, and of the midplane, 125.
7. Eighty-five percent of the normal capacity of either the inlet or midplane indicates a borderline situation.

Specifically, roentgen mensuration is indicated:—

1. When there is a history of difficult deliveries.
2. When the head is unengaged at term in a primiparous patient.
3. When the patient is an elderly primipara.
4. When there is a breech, face, transverse lie, or other abnormal presentation.
5. When the sacral promontory is readily palpated.
6. When there is any sacral deformity.
7. When the ischial spines are prominent.
8. When the pubic arch is pointedly narrow.
9. When the bi-ischial diameter of the outlet is less than 8 cm.
10. When the sum of the bi-ischial and posterior sagittal diameters of the outlet is 15 cm. or less.
11. When labor is unduly prolonged.

Although pelvioradiography may be rightfully



rated among the great obstetric advances, there are several factors that may interfere with its dependability being wholly complete; for example:—

1. Pelvioradiography cannot predict the *power of uterine contractions*.
2. It cannot estimate the *moldability of the cranial bones*.
3. It cannot inform us as to the favorability or "*ripeness*" of the *cervix*.
4. It does not differentiate against *elderly primiparity*.
5. It does not accurately disclose the *size of the baby*, particularly when conditions are not suitable for proper estimation. (May I interject, just how closely can we estimate the size of the baby in utero, clinically or otherwise, when after birth, holding it in our hands, we sometimes miss its weight 1 to 2 pounds?)
6. It does not take into consideration the dystocia of *abnormal presentations*.
7. It cannot profit from the *obstetric history in multiparous cases*.
8. It cannot detect or evaluate *soft tissue dystocias*;
9. It cannot appraise the nervous stability of the patient, and finally,
10. It disregards the *skill of the obstetrician*.

Of all the components of cephalopelvic disproportion, only one can be accurately measured, namely, the size and shape of the bony pelvis.

The disregard for moldability of the head and the power of the uterine contractions, and poor roentgen technic and faulty interpretation of roentgenograms account for a great number of unnecessarily performed cesarean sections.

Radiographic pelvimetry and fetometry should be considered only diagnostic aids, and when they run counter to clinical findings, one should not set aside seasoned clinical experience. On this basis, and in view of the required technical interpretation and involved expense, the routine roentgenography of all primiparous patients would seem to be an unnecessary practice. Such a study would be in order only if indicated by the clinical examination. The clinical examina-

tion should estimate the conjugate vera and make careful note of the concavity of the anterior surface of the sacrum, the proximity of the spinous processes, and the width of the sciatic notch.

Routine x-ray pelvimetry should not replace manual evaluation of the obviously adequate pelvis, but manual evaluation of the borderline pelvis should be supplemented by roentgenographic study.

In dealing with the problem of cephalopelvic disproportion, one should not assess the pelvis except in its relation to the size of the baby that is to pass through it. Unfortunately, x-ray fetometry is of very little practical use, except in very expert hands, and has no worth in such presentations as breech and transverse lie.

The extent of disproportion in nonengagement should be determined near term. This can be accomplished clinically by using the Müller's method, which is performed as follows: With the patient in the dorsal position, an assistant attempts to press the head into the inlet, while the examiner with two fingers in the vagina determines the size and compressability of the head and the extent of its descent. With his external hand, he notes the degree of overlapping at the symphysis. He may gain more information by using the Hillis maneuver, in which working alone, the operator standing at the side of the patient in a semilithotomy position, places one hand over the top of the fundus (breech) and attempts to force the baby down through the pelvis along the curve of Carus, at the same time noting the degree of the descent of the head with the index finger of the other hand inserted into the rectum. The descent in relation to the spines is more readily noted than per vaginam. Either method may require anesthesia.

If the head surface bulges to a line in front of the symphysis, the disproportion is *moderate*, and barring preossification of the cranial bones, and other things being equal, spontaneous delivery is likely. If the head bulges in front of the symphysis, there is *marked* disproportion, and delivery of a living baby from below is unlikely.

The management of labor in contracted pelvis will depend upon:—

1. Degree of contraction.
2. Size and presentation of the child.
3. History of previous labors.

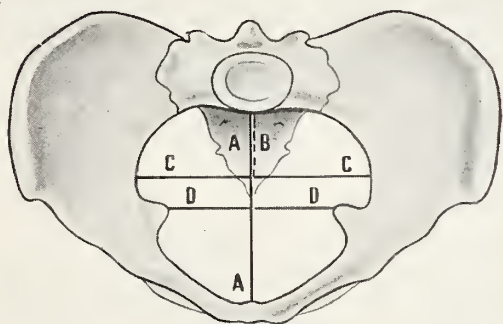
- (a) If C.V. is 5.5 cm. or less, an elective section. (The baby cannot be delivered from below even by embryotomy.)
- (b) If the C.V. plus the transverse diameter of the inlet equals 20 cm. or less, elective section without trial labor.
- (c) If the head bulges beyond the front of the symphysis (marked disproportion) a short trial labor, usually section, at least mid-forceps or version.
- (d) If the head bulges to a line in front of the symphysis (moderate disproportion) trial labor, as long as justifiable, spontaneous or low forceps delivery is the rule. However, if no engagement after a six hour trial labor, a decision to do a section is in order, even if the cervix is not completely dilated.

Inlet contraction is usually associated with mid-pelvic contraction, and it warrants further accurate study of the internal pelvis. As before stated, this can be done only by x-ray, and is best accomplished by anteroposterior and lateral films.

The term "mid-pelvic contraction", as now used, refers to a contraction of the narrow pelvic plane, which for obstetrical purposes passes through the apex of the pelvic arch, the ischial spines, and the junction of the fourth and fifth sacral segments. The interspinous line divides the plane into an anterior and posterior portion. The dimensions of the normal mid-pelvic plane are:—anteroposterior, 11.5 cm.; transverse or interspinous, 10.5 cm.; and the posterior sagittal, 5.0 cm.

FIG. 1 CLINICALLY IMPORTANT PELVIC DIAMETERS AS SEEN FROM ABOVE

A-A Anteroposterior diameter of the inlet; B, posterior sagittal diameter of the inlet; C-C, transverse diameter of the inlet; D-D, interspinous or transverse diameter of the narrow pelvic plane.



The relation of the bi-ischial diameter of the outlet to the interspinous of the midplane is so constant, when the former is found shortened that of the latter should be investigated. However, very occasionally, the bi-ischial alone is shortened, and unless the posterior sagittal of the outlet compensates amply, serious obstruction may be at hand. This is the case when the sum of the two is less than 15 cm.

Pelvic outlet contraction, if not detected, is more serious than undetected inlet contraction. In the latter, disproportion is recognized early in labor, and section can be performed before severe untoward conditions and symptoms develop.

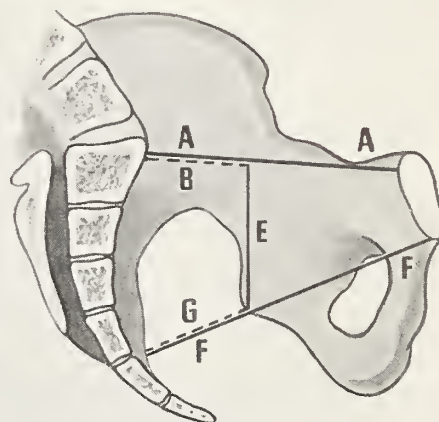
*Cesarean section is often as rationally indicated at the outlet, as at the inlet.*

### Abnormal Presentations and Positions

Although a less important factor in protracted labor than cephalopelvic disproportion, abnormal presentations and positions do present a definite role. The most common example is the *occiputposterior position*. The chief etiologic factors are the anthropoid android pelvis and minor degrees of flat pelvis. These can be recognized at an early antepartum visit by a careful clinical examination, supplemented, if necessary by radiography.

FIG. 2 CLINICALLY IMPORTANT PELVIC DIAMETERS AS SEEN FROM THE LATERAL ASPECT

A-A Anteroposterior diameter of the inlet; B, posterior sagittal diameter of the inlet; E, anteroposterior diameter of the narrow plane; G, posterior sagittal diameter of the narrow plane. When the sum of the transverse and the posterior sagittal is 13.5 cm. or less, dystocia is likely. When the interspinous is less than 9.5 cm., mid-plane contraction is most probably present, sometimes warranting section.



Early diagnosis of the posterior position is desirable not only in order to be prepared for possible complications, but to be able to inform the family of a likely prolonged labor.

In way of abdominal diagnosis, if given a case of but one baby, lying longitudinally and kicking "all over" (both sides of the abdomen) a posterior position is strongly suggested. This position can then be confirmed by performing the "C" grasp maneuver, described as follows:

The attendant facing the patient and standing at her right side, depresses the umbilicus with the right thumb held vertically well into the fetal triangle, and then takes a "C" grasp with the thumb and first two fingers of the right hand applied to the left side of the abdomen along a transverse plane passing through the umbilicus. At the same time, the left hand is placed longitudinally along the side of abdomen, and presses toward the grasping right hand, attempting to displace the baby's body into the grasp of the right hand. This part of the maneuver is then repeated on the right side of the abdomen by pivoting the right hand on the thumb transferring the left hand to the left side of the abdomen.

In performing the maneuver, in one instance a "somethingness" (baby's body) is felt within the grasp, in the other a "nothingness" will be noted. The OLP or ORP position will be identified by a maximum pressure localized at the tips of the first two fingers of the right hand. The OLA and ORA positions are indicated by a maximum pressure over the tarsophalangeal joints of the first two fingers, and the OLT and ORT positions by pressure over the first phalangeal joint of the fingers.

The posterior position is best verified by palpating the free margin of an ear with a vaginal hand. Occasionally palpation of the eyes, chin, or neck is more helpful.

The handling of persistent occipitoposterior, among other circumstances, will depend upon the station at which the arrest has occurred. If the head is low, manual rotation and forceps delivery suffices in most cases. Or one may choose forceps rotation according to the Scanlon technic, with the privilege of modifications. In those cases where the occiput can either be rotated easier into the hollow of the sacrum or where it has already done so, the case is best handled by a wide mesiolateral episiotomy and

a forceps delivery, bringing the occiput over the perineum and the face beneath the symphysis, remembering to hyperflex the head until the brow emerges, and then follow with extension. With a well molded head, there should be no difficulty. If the cervix is not completely dilated, but well effaced, Dührssen's incisions may be employed.

With occiput posterior, the head high or unengaged, and proportions ample, internal podalic version is often preferable to forceps. If the head is high and there is disproportion, or if the patient is an elderly primipara, cesarean section is usually best indicated.

*Breech presentation* carries among general practice a fetal mortality of 12 percent, and among obstetric specialists, 3 to 5 percent. It appears evident from the baby's viewpoint, it would fare better if such a presentation could be averted, or if all such presentations could be delivered other than through the pelvic canal. There can be no question about prophylactic external version eliminating much breech mortality and morbidity.

Although it is not our purpose to instruct as to how to diagnose a breech, those who are not familiar with Mengert's maneuver will find it very practical. It is designed to differentiate between the head and the breech, a feat sometimes not so simple. Slow, firm, steady compression of the fetal head by a grasping hand produces a marked slowing of the fetal heart rate from 140 to 90 or less beats per minute, or even a temporary abolition of the tones. A similar compression applied to the breech has no such effect.

The pelvis of every breech case should be carefully evaluated, and a flat plate taken of the abdomen not only to confirm the diagnosis of breech but to reveal the variety of breech, and disclose defective attitudes. The frank breech, because of its splinting effect upon the fetal trunk, is the most dystocic variety.

All breech deliveries should be conducted in a hospital, and there should be in readiness an able assistant, surgical ether, and a pair of forceps.

If progress comes to a standstill or delivery is demanded, and there is no gross disproportion, then and not before then should extraction be attempted. It is imperative the cervix be com-



pletely dilated, and highly desirable the rest of the maternal soft parts be fully distended by the fetal body, and a wide mesio-lateral episiotomy be done.

In case of a frank breech, either groin traction by the index fingers or the Pinard maneuver is useful. Flexion of the head in order to prevent extension of the arms should be maintained by the assistant. The after-coming head is best delivered by forceps (Piper) or the Mauriceau-Smellie-Viet maneuver. Anesthesia should be surgically deep during delivery of the shoulders and head, and particularly, if the complication of extended arms arises.

If there is gross disproportion because of pelvic contraction or the size of the baby, or if the patient is an elderly primipara with any pelvic contraction, cesarean section is by far the method of choice. *More breech presentations should be delivered by abdominal section.*

In *face* presentation spontaneous birth is generally possible only if the chin is anterior or transverse. If arrest occurs, then deep episiotomy and forceps delivery are in order. If the chin is obliquely posterior patience is required the same as in occiput obliquely posterior, since both rotate late in labor. However, this position almost routinely calls for interference. If attempted conversion into flexion fails, and it usually does, then rotation, manually rather than by forceps, should be attempted. If successful, then delivery by forceps, should be attempted. In many cases, if conditions are favorable, internal podalic version and extraction is the procedure of choice. If the chin or mentum is directly posterior, interference is mandatory. Since in protracted cases conversion is almost impossible, and success of rotation is unlikely, cesarean section is indicated.

In *face* presentation, as in others, if there be disproportion, through pelvic contraction or oversized baby, an elderly primipara, or a history of stillbirths, abdominal delivery should be the method of first choice.

A *brow* presentation is usually transient. At the beginning of labor it either flexes into a vertex or extends into a face and labor progresses. If it persists it is definitely dystocic and since there is no mechanism, labor slows to a standstill. Under such a circumstance, when dealing with a normal pelvis, early in labor, the axiom "Flex

if you can—extend if you must" should ring out. If successful, then spontaneous delivery or forceps. If failure in conversion, then if conditions are favorable, internal podalic version should be done. If head well molded, forceps may be attempted, but with caution.

If the pelvis be small or if disproportion exists from other causes, cesarean section is by far the best procedure.

*Transverse lie* is the third variety of presentation that is without mechanism; the other two being the mentum directly posterior and the brow. Unless corrected antenatally by external cephalic version, prolonged labor is inevitable. There is no expectancy, and trial labor has no place here.

Management in general depends upon the parity of the patient. If a primipara, a transverse lie usually suggests pelvic contraction and an elective cesarean section is indicated. The abdominal route is indicated even though the pelvis be normal. External version is rarely successful in a primipara, and internal version is usually contraindicated because the cervix is rarely completely dilated.

In multipara, external cephalic version may be successful even in early labor, and the head brought into the pelvis. If not achieved, membranes ruptured, and cervix not fully dilated, cesarean section is in order. When cervix becomes fully dilated, internal podalic version and extraction should be done at once. With membranes ruptured, one should anticipate the common complication of prolapsed cord.

In a neglected transverse lie, internal podalic version is contraindicated because of risk of rupturing uterus. If baby is alive, then cesarean or cesarean hysterectomy should be done. If the baby is dead or near dead, a decapitation or evisceration and spondylotomy should be performed.

### Uterine Inertia

Uterine inertia, the third important cause of prolonged labor, is rightfully a source of much concern, and the manner of management depends upon whether it is primary or secondary. In other words, whether we are dealing with a lazy horse needing stimulation, or a tired horse needing rest. In the absence of bony dystocia, abnormal position, or obstruction, the inertia is due to a deficient *vis a tergo*, and if adequate

periods of rest and ample fluids do not achieve progress, then intravenous pitocin drip may be resorted to, providing proper technic is cautiously followed. When the cervix is half or more dilated, the action of the pitocin can often be augmented by rupturing the membranes. After complete dilation of the cervix, the delivery may be terminated by forceps. However, if progress has not been forthcoming, and if labor has lasted as long as 36 to 40 hours, or if the case be one of elderly primiparity, abdominal section should be done.

Secondary inertia should not be handled by pituitary or pitocin stimulation, except perhaps in its early stages. Three or four hour intervals of sedation, sleep, and ample intravenous glucose solution are often helpful in getting progressive labor re-established. If the cervix attains complete effacement, Dürrhsen's incisions, followed by low or midforceps, may be the answer. Here again, if we are satisfied the patient can achieve no more, for her good or the welfare of the baby, cesarean section should not be postponed, particularly, since secondary inertia is so often associated with obstructed labor.

### Some Less Frequent Factors

*Cervical dystocia*, whether primary or secondary, and even though rare, is an entity in the problem of prolonged labor. The management varies with the basic factor at hand. Conglutination of the external os, that condition in which the cervix is fully effaced and dilated except for resisting circular fibers about the os, is usually readily handled by rupturing the membranes and manual dilatation. If this fails, the most to be required is Dürrhsen's incisions, followed by forceps delivery.

Long, hard, rigid, cervixes should be recognized early in labor and dystocic effects anticipated. Even though complete dilatation may be achieved by strong uterine powers, in many instances it is accomplished at risk of fetal damage or death, and cervical lacerations. In many cases, certainly in elderly primipara, there should be timely interference in way of either cesarean section, or conditions permitting the alternative, Dürrhsen's incisions and forceps.

The rigid, non-yielding cervix, resulting from infection, trauma, or surgery is so slow to efface and dilate, that expectant treatment carries too

great a risk. An early, low segment section and antibiotics, if indicated, give better results than a difficult forceps delivery. However, if the cervix is sufficiently effaced, crucial incisions and forceps may be the operation of choice.

*Unruptured membranes* may protract labor either by being tough or by interfering with dilatation through their adherence about the internal os. Because of this factor, in order to get the maximum effect, before performing the actual puncture one should thoroughly strip the membranes by sweeping the index finger both clockwise and counterclockwise.

Rupturing the membranes is most effective when the cervix is at least 5 cm. dilated, and is frequently useful and often invaluable when labor is arrested by delayed rotation and in cases of borderline pelvic dystocia. When the result is not sufficiently effective, it often can be made so by augmenting with pitocin drip.

*Tumor obstruction* to labor is rare. It commonly arises from low segment or cervical fibroids and impacted ovarian tumors. Very rarely obstructive tumors arise from the pelvic wall; again, the offending mass may be a pelvic ectopic kidney.

The management, unless dealing with a dead baby that can be removed vaginally by embryotomy, is 100% cesarean section. If the tumor mass is a fibroid, a section hysterectomy is often in order. Ovarian tumors can be removed at the time of the section. Dermoid cysts, if possible should be removed without rupturing or perforation. One should not be tempted to puncture an ovarian cyst per vaginum. The danger of peritonitis is great, especially if it is a dermoid.

*Elderly primiparity*, that is patients 35 years of age or older, in general does not in itself signify formidable labor risk, at least to the mother. The chief factors differentiating her labor and that of younger patients is the dystocia arising from her inelastic soft parts and the rigid pelvic synchondroses. Her real handicap comes mainly from the increased incidence of vascular and cardiac disease, toxemia, uterine fibromata, placenta previa, premature separation of the placenta, operative interference, and postpartum hemorrhage. In that these complications increase with age, the evaluation of the labor of a primiparous patient 40 years or older, is proportionately important.

In managing elderly primiparity, expectancy can be safely applied to most cases. However, a greater recourse to forceps and cesarean section is justified. Section is more indicated than among younger women, when dealing with breech or occiput posterior presentations, pre-eclampsia or borderline pelvic contraction. Likewise, the added premium on the baby should increase the incidence of abdominal delivery.

Babies born to elderly primipara carry a risk of life of about three times that of the general rate, and the rate increases with the maternal age increase. The high incidence (50%) of unengaged head at term is a prominent factor.

*Pathologic retraction ring* is an added factor in prolongation of labor in obstructive labor cases. The associated high maternal (15%) and infant (52%) mortalities make it a serious complication.

The diagnosis can be made absolutely only by palpation from within the uterus. However, it may be suspected when, during prolonged labor, the uterine pains become irregular and moderate, of a severe colicky type. The ring is sometimes visible and palpable across the lower abdomen. Again, it may be surmised when failing to deliver by forceps or breech extraction.

The management will depend upon the cause of the obstruction and the condition of the mother and the baby. If delivery is to be conducted from below, even by embryotomy, there must be complete relaxation of the uterus. This is best obtained by deep anesthesia, either ether or chloroform. Various antispasmodics frequently suffice. Those found to be helpful are amylnitrite, 1 to 2 ampules administered by inhalation; adrenalin, given hypodermically in 8 minim doses, (dangerous to the heart when in conjunction with chloroform); and magnesium sulfate, 1 gram intravenously.

Not infrequently all these measures fail, and the only alternative is cesarean section, particularly if there is a sudden drop in the fetal heart rate. If the baby is dead, expectancy may allow relaxation and permit delivery from below. However, if the mother continues to be jeopardized by exhaustion or threatened uterine rupture, section, likely Porro, should not be postponed.

### Some Reminders and Guiding Helps in the Management of Prolonged Labor

1. Seventy-five percent of contracted pelvic cases can be safely delivered from below.

2. When a trial labor is once decided upon, the conduct of the case should be favorable to the possibility of cesarean section. Both vaginal and rectal examinations should be limited.

3. In dealing with borderline pelvis, trial labor may be allowed to continue as long as progress is satisfactory, and a trial forceps may be attempted even in view of a possible section.

4. The vaginal examination should be the one of choice, in that it affords more accurate information, as to the degree of engagement, the moldability of the head, cervical dilatation, and the status of the membranes. It also assists in determining the degree of the flexion of the head, and notes, if present, lateral flexion manifested by asynclitism, generally indicating the need for section delivery. And not least, it frequently aids in correcting an error in diagnosis of position.

5. A timely rupture of the membranes will often increase progress, particularly when the cervix is two thirds or more dilated. When the cervix is completely dilated, the membranes, if intact, *should* be ruptured.

6. If membranes have been ruptured six or more hours, antibiotics should be given, to be repeated every 12 hours throughout the labor.

7. The transperitoneal cervical section combined with antibiotics can safely replace the extraperitoneal type in potentially or even frankly infected cases.

8. Rest by morphine or demerol at indicated intervals, ample hydration (orally or parenterally), nutrition by intravenous glucose, and adequate antibiotic therapy are indispensable aids.

9. When there is a primary inertia or a beginning secondary inertia, providing there is no disproportion, intravenous pitocin drip is a helpful adjunct in most instances.

10. The fetal heart rate should be checked every half hour, or oftener if it increases to over 160, and oftener yet, if slowed to less than 120. If irregular and slowed to 100 or less, it



should be supported by intranasal oxygen to the mother, while plans for immediate termination of labor are in progress.

11. Because of the likely risk of cerebral damage, babies born after prolonged labor should be protected by vitamin K administered through the mother during labor, and directly to the baby following birth. Many of these babies are benefited by incubator care for at least the first 24 to 36 hours.

12. The prognostic interpretation of roentgenograms should be the responsibility of the obstetrician and not of the roentgenologist. As some one has stated, "The obstetrician can master the technic of roentgenologic pelvimetry in a comparatively short time, but the roentgenologist cannot become an obstetrician in that same short time."

13. Dead and dying babies, and those in cases in which any other form of delivery would jeopardize the life or the health of the mother, should be delivered by embryotomy. Whether the procedure should be a craniotomy, decapitation, evisceration, or spondylotomy, would depend upon the circumstances at hand.

14. Finally, in dealing with protracted labor, there should be at all times a sincere effort on the part of the attendant to maintain assurance and encouragement for both the patient and the family. (And privately, some of the same for himself.)

In way of a concluding statement, general agreement would hold that prolonged labor is constantly fraught with pitfalls, and it may be said of him, who knows *when to interfere, when not to interfere, and how to interfere*, "He is thrice and happily wise."

## SCRUB TYPHUS

### Big World War II Killer Hasn't Caused a Death Among Soldiers Fighting in Malaya

Scrub typhus, the disease that killed hundreds of Allied and Japanese troops in the Burma campaign during World War II, hasn't claimed a single soldier now on active service against Malaya's Communist terrorists.

Capt. D. H. de T. Reade, military information officer on non-tactical subjects attached to Head-

quarters Malaya in Kuala Lumpur, said the reason is "the wonder antibiotic Chloromycetin, which has proved 100 percent effective in cutting it. So swift is the cure that soldiers generally can be back on duty within a week. By older methods of treatment, they were away two to six months, and very often one in four died."

# OSSIFICATION IN UNUSUAL LOCATIONS

## 3 Case Reports\*

HERBERT H. INLOW, M.D.

*Shelbyville*

**T**HEORETICALLY, ossification can occur anywhere that fibrous tissue is present. Actually, it is rather uncommon except in healing fractures, about dislocated joints, and in hematomata.

These cases seem to me to be unusual because of the position of the ossification, and tend to confirm the statement above.

**Case I.** Mr. E. R., age 60, a farmer, came to us on May 31, 1949, complaining of pain and soreness in the bottom of his left heel, present for 4 months. He had no history of injury to the



Fig. 1

heel. There was a small area of localized tenderness over the inferior surface of the os calcis. Film of the left heel (Fig. 1) shows a tiny cal-

Herbert H. Inlow, M.D., Shelbyville specialist in radiology and staff member of Inlow Clinic, is a 1923 graduate of Rush Medical College, Chicago. He is certified by the American Board of Radiology, is a member of the Radiological Society of North America and the American College of Radiology.

canal spur and considerable calcification in the arteries. Along the posterior margin of distal end of tibia, but separate from it, there is a flat layer of ossification, about 4 x 25 mm. in size, shaped like a convex lens. This film is practically identical with the diagram in Figure 89, page 139, of Köhler's Röntgenology. He is of the opinion that "we are dealing really with a tearing off of the posterior malleolar ligament together with the periosteum proximal to it, with subsequent ossification."

Further inquiry into the patient's past history failed to elicit anything suggestive of old trauma about this ankle-joint, although it is possible that he has forgotten some incident which he considered minor at the time.

**Case II.** Mr. J. McD., a salesman, was referred to us by Dr. W. C. McFadden (deceased), of this city, on April 12, 1937, for x-ray films of his right lower leg and ankle.

The patient had a right club-foot at birth, which was corrected at six months of age by "clipping" the Achilles tendon. In 1928, he jumped off a platform and struck the back of his right lower leg against a car bumper. The leg became sore and swollen, but no bruise appeared. Later, he noticed a hard lump in this

\* From the Inlow Clinic, Shelbyville.



Fig. 2

area, which got sore and swelled if he walked much. The tender area had several x-ray treatments; dosage and other factors unknown.

The film (Fig. 2) showed a large irregular mass of bone, about  $8.3 \times 2.1 \times 2.0$  cm. in its maximum dimensions, located in the region of the Achilles tendon and entirely separate from the os calcis.

Examination of the leg showed a large palpable mass which was essentially part of the Achilles tendon.

A recheck x-ray examination (Fig. 3) on June 21, 1949, showed that the mass of bone had increased in size to  $9.6 \times 2.2 \times 2.1$  cm. since 12 years before, with no particular change in the amount of discomfort.

In this case, there is a definite history of operative procedure, and later, trauma, to the site of ossification.

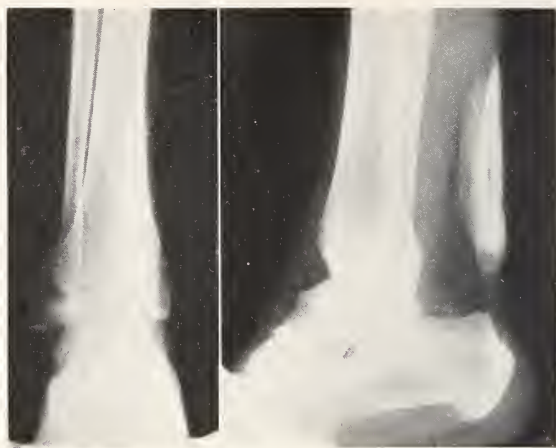


Fig. 3

**Case III.** Mrs. H. F., age 82, was a patient of Drs. R. W. Gehres and L. F. Hulsman, Shelbyville. These physicians gave me the specimen described later because of my interest in it.

This aged woman was sent into the hospital on July 15, 1931, complaining of intense pain in the left eye, referred to the whole left side of her head. The present episode had been present for about two weeks.

She gave a history of an injury to the left eye when she was nine years of age, resulting in blindness. There had been occasional attacks of pain in this eye since that time, similar to, but less intense than the present complaint.

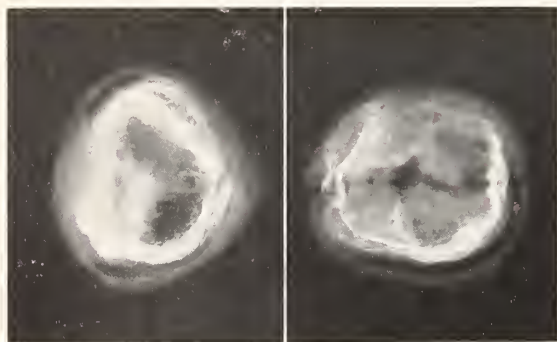
Under ether anesthesia, given by Doctor Gehres, the left eye was enucleated on the day of admission by Doctor Hulsman. The patient made an uneventful recovery and was discharged from the hospital five days later.

Examination of the excised eyeball showed it to be shrunken and quite hard. It was 22 mm. in size in its anteroposterior diameter, 24 mm. wide, and 22 mm. high. On cutting it into halves, this density seemed to be due to a shell of bone.

X-ray films of the eyeball (Fig. 4) show it somewhat smaller than normal, with a thin irregular layer of bony structure present, which is probably in the sclera.

Trauma, followed by repeated inflammations (and infection?) over a long period of years, gives an adequate cause for the findings in this case.

Fig. 4





# BLEEDING FROM PEPTIC ULCER:

## A Review of 327 Cases

D. G. BOCK, M.D.\*

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**M**ANY PROBLEMS concerning bleeding from peptic ulcer remain unanswered. A need for further statistical study is apparent in order to shed light on certain aspects of prognosis, mortality, and therapy of bleeding ulcers. A report has recently been made which was based on a study of 223 cases of bleeding peptic ulcer from the Indiana University Medical Center, Indianapolis, Indiana<sup>11</sup>. It was thought that a similar survey in a large open-staff, private hospital in the same community would be of interest from a comparative point of view. With this thought in mind 327 cases of hemorrhage from proven peptic ulcers treated in the Methodist Hospital, Indianapolis, Indiana, between January 1, 1946 and January 1, 1952, were reviewed. These cases were treated by internists, surgeons, and general practitioners. The entire group of 327 bleeding peptic ulcers has been studied as a whole, without regard to the service upon which the patient was admitted.

Such matters pertaining to prognosis as the effect of degree of hemorrhage, the number of hemorrhages, location of ulcer, and age of the patient have been much discussed in the literature. Recently, a review of 16,172 reported cases has been published by Crohn and Janowitz<sup>5</sup>. It was apparent from this review that unanimity of opinion was lacking in certain matters pertaining to bleeding peptic ulcer. For example, it has been contended that the first hemorrhage is more likely to be fatal than subsequent hemorrhages. Blackford and Williams reported 116 cases in which 78% of all deaths from ulcer hemorrhage occurred during a first hemorrhage<sup>1</sup>, and in the series previously reported from the Indiana Uni-

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Rollin H. Moser, M.D., is a 1922 graduate of Rush Medical College, Chicago, and is in the private practice of internal medicine in Indianapolis.

versity Medical Center, the mortality rate for first hemorrhage was 90%. However, a series of 1,455 cases collected by Ivy, Grossman, and Bachrach indicated that when an adequate number of cases were analyzed, a significant difference in mortality between first and subsequent hemorrhages was not found<sup>8</sup>. This question has yet to be settled.

The relationship between ulcer pain and bleeding has not been entirely clear. It is frequently heard that, "A bleeding ulcer doesn't hurt". This has been explained by Carlson as being due to a lack of gastric tone, by Bonney as caused by the presence of blood in the crater covering the pain nerve ends and hindering their excitation by hydrochloric acid, and by Van Liere as the neutralizing effect of blood (in the stomach) on gastric acidity<sup>13, 3, 14</sup>. It is stated by Bockus that the continuation of pain following a severe hemorrhage usually means a lack of ulcer healing and may herald continued bleeding.<sup>2</sup> Evaluation, again, is difficult.

Many unsettled problems exist in regard to therapy, both medical and surgical. It has been long debated whether to feed the bleeding ulcer patient promptly, or whether to delay feedings. The trend at present seems to be toward prompt feeding<sup>13, 8</sup>.

It is also problematical whether a patient with a bleeding peptic ulcer should be transfused. Most authors now seem to agree that the giving

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of blood in amounts adequate to relieve shock and to maintain the red blood count and hemoglobin at reasonable levels is indicated<sup>16, 12, 4</sup>. Pollard and Wollum, on the other hand, state that blood should not be given unless there is definite shock or the hemoglobin is below 50%<sup>9</sup>. The present study will add to the statistics regarding transfusion and should help to elucidate this problem.

Should the surgical approach to bleeding peptic ulcers be radical or conservative? If surgery is to be performed, should it be early (within the first 48 to 72 hours of hemorrhage), or can it be done safely after 72 hours of continued bleeding? Or, would it be more desirable to wait in anticipation of cessation of bleeding, and then operate at a later date? A series of 155 patients with continued bleeding collected by Ivy, Grossman, and Bachrach operated upon within 48 to 72 hours, and another group of 116 cases operated on after cessation of bleeding, suggests a markedly higher mortality rate in those patients operated on after 72 hours<sup>8</sup>. The lowest surgical mortality was among those having elective surgery after bleeding had stopped.

Severity of Hemorrhage

The classification of bleeding peptic ulcer according to severity of hemorrhage has certainly not been agreed upon. Hemorrhage may be classified as Grades 1, 2, 3, and 4 (Rafsky and Weingarten); as moderate, severe compensated, severe uncompensated, or exsanguinating (Hoerr, Dunphy and Gray); as slight, intermediate, or massive (Warthin); or by dividing all cases into four classes on the basis of the lowest red blood count and hemoglobin determination (Fisher and Zuckerman)<sup>10, 7, 15, 6</sup>. The fact that severity of hemorrhage has been classified in so many ways is unfortunate. In order to provide a closer comparison with the recent series of 223 cases of bleeding peptic ulcer from the Indiana University Medical Center, we have chosen the criteria of Fisher and Zuckerman. It is appreciated that certain errors are inherent in this method of classification, namely that the red blood count and hemoglobin determinations were sometimes made at the time of severe exsanguinating hemorrhage before the red blood count and hemoglobin levels had adjusted to the altered blood volume. Also, on occasion, red blood counts and hemoglobin determinations were made after

the patient had been transfused one or more times, giving a higher reading than actually existed at the time of hemorrhage.

Of 327 cases analyzed, 201 (61.1%) fell into Groups III and IV. Thus, nearly two-thirds of these cases may be considered to have had massive hemorrhage. There were 105 (32.1%) cases in Group II and 21 (6.4%) cases in Group I. There were 19 deaths in the entire series (5.8%). Of these deaths, 16 (84.2%) occurred in Groups III and IV. The remaining three deaths (15.8%) occurred in Groups I and II. Of these three patients, one died of sudden exsanguinating hemorrhage, one died five days post-gastrectomy of auricular fibrillation and congestive heart failure, and the third, after 13 days of continuous hemorrhage, died of myocardial infarction. The red blood count and hemoglobin determinations in these three cases were not made at the time clinical hemorrhage was most severe. However, it becomes readily apparent from this study that the prognosis of a bleeding peptic ulcer patient parallels closely the severity of hemorrhage. (Table I).

TABLE I  
Distribution according to severity of hemorrhage

	Group I HB. 12 RBC 4.0	Group II HB. 9-11.8 RBC 3.0-3.99	Group III HB. 6.8-8.8 RBC 2.25-2.99	Group IV HB. 6.8 or less RBC 2.25 or less	Total
No. Cases -----	21	105	83	118	327
No. Deaths -----	0	3*	5	11	19
% Deaths -----	0	2.9	6.0	9.2	5.8

\* These 3 patients died of exsanguinating hemorrhage. Only laboratory studies done on admission were available for classification.

Location of Ulcer

Of the 327 cases analyzed, 296 (90.5%) had duodenal ulcers, 16 (4.9%) had gastric ulcers, 15 (4.6%) had both gastric and duodenal ulcers, and none had jejunal ulcer. It is interesting to note the low percentage of gastric ulcers in this series.

Of the 19 deaths, 14 (73.7%) occurred in patients with duodenal ulcer, 4 (21.1%) in those



with gastric ulcer, 1 (5.3%) in those with both gastric and duodenal ulcers. (Table II).

TABLE II  
Location of ulcer

	Duod.	Gastric	Duod. Gastric	Jejunal
No. Cases -----	296	16	15	0
No. Deaths -----	14	4	1	0
% Deaths -----	4.7	25.0	6.7	0

### Age Distribution

In this series of 327 patients there were 215 (65.7%) who were over 45 years of age. Of the 19 deaths which occurred in the entire group, 18 (94.7%) were beyond 45 years of age. These statistics confirm those of most writers, that the incidence of bleeding peptic ulcer is greater in those patients over 45 years of age, and that the prognosis becomes progressively worse in the latter decades of life. (Table III).

One hundred and ninety-four (59.3%) patients were admitted during their first episode of bleeding. It was this group which accounted for 17 (89.5%) of the deaths. The number admitted during their second hemorrhage was 81 (21.4%). In this group two patients died, accounting for 10.5% of the deaths. There were

30 (9.2%) patients admitted during their third episode of bleeding, and 22 (6.7%) admitted for their fourth or more bleeding episode. No fatalities were encountered in the latter two groups. These figures further confirm the belief that the prognosis from bleeding peptic ulcer is much worse during the first episode of bleeding than from subsequent bleeding episodes. The opinion, often expressed, that patients bleeding from a peptic ulcer for the first time have a much lower mortality than patients who have had previous episodes of hemorrhage, is not substantiated by this study. (Table IV).

### Symptoms on Admission

Table V lists the symptoms on admission in the order of their frequency. The symptoms of melena, epigastric pain, and hematemesis were most frequent. Of those patients who survived, 171 (52.3%) experienced pain during bleeding, while of those patients who died during active hemorrhage 8 (42.2%) experienced pain. Both of these figures are probably conservative, because in some instances it was felt that the symptoms were not fully recorded on the protocols. It is worth noting that pain was present in about an equal percentage of those patients who lived and of those who died. Certainly, the idea that pain disappears when a peptic ulcer bleeds is not substantiated by this study. It is

TABLE III  
Age distribution

	—19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	Total
No. Cases -----	0	9	13	29	26	35	37	40	44	26	68	327
No. Deaths -----	0	0	0	0	1	0	1	1	4	0	12	19
% Deaths -----	0	0	0	0	3.9	0	2.7	2.5	9.1	0	17.6	5.8

TABLE IV  
Episode of bleeding

	Total of Series	First		Second		Third		Fourth	
		No. Cases	% of Total	No. Cases	% of Total	No. Cases	% of Total	No. Cases	% of Total
No. Cases -----	327	194	59.3	81	24.8	30	9.2	22	6.7
No. Deaths -----	19	17	89.5	2	10.5	0	0	0	0
% Deaths -----	5.8	8.3	0	2.5	0	0	0	0	0

TABLE V  
Symptoms on admission

	No. Cases	No. Deaths	% Deaths
Melena -----	241	15	6.2
Hematemesis -----	155	13	8.4
Pallor -----	70	11	15.7
Weakness -----	126	10	7.9
Syncope -----	56	8	14.3
Vertigo -----	28	1	3.6
Epigastric Pain ----	171	8	4.6
Sweating -----	60	5	8.3
Dyspnea -----	38	3	7.9
Diarrhea -----	47	5	10.6

difficult from these figures to ascertain just how much prognostic value pain is. Many writers, however, state that persistent epigastric pain in a bleeding peptic ulcer patient is an unfavorable sign.

Physical Findings on Admission

Physical findings on admission and correlation of the mortality rate for cases presenting each are listed in Tables VI and VII. The incidence of physical findings for those patients who died is as follows: pallor, 15.3%; shock, 14.3%; pulse over 100, 11.7%; systolic blood pressure 100 mm. or less, 20.5%. Again, the figures given in Tables VI and VII are probably deficient. In several cases it appeared that the histories were not adequately detailed, and in some instances the physical findings were not recorded at the time the symptoms were most pronounced. It would appear that the patient's

TABLE VIII  
(a) Time of feeding

	Immediate Feeding	24 Hour Delay	48 Hour Delay
No. Cases -----	127	32	168
No. Deaths -----	6	0	12
% Deaths -----	4.7	0	7.1

(b) Relation between severity of hemorrhage and feeding

Severity	Immediate Feeding				24 Hour Delay				48 Hour Delay			
Group	1	2	3	4	1	2	3	4	1	2	3	4
No. Cases -----	8	47	35	37	2	13	7	10	11	45	41	69
No. Deaths -----	0	0	2	4	0	0	0	0	0	3	1	8
% Deaths -----	0	0	5.7	10.8	0	0	0	0	0	6.7	2.4	11.6

TABLE VI  
Systolic blood pressure on admission

Systolic B.P. In MM. HG	50-60	60-70	70-80	80-90	90-100	100-110	110
No. Cases -----	6	10	7	20	25	37	222
No. Deaths -----	1	0	1	3	2	1	11
% Deaths -----	16.7	0	14.3	15.0	8.0	2.7	4.9

TABLE VII  
Physical findings on admission

	No. Cases	No. Deaths	% Deaths
Pallor -----	72	11	15.3
Temp. over 99° F.---	63	4	6.4
Pulse over 100 -----	77	9	11.7
Sweating -----	49	1	2.0
Shock -----	35	5	14.3
Dyspnea -----	27	1	3.7

physical findings are important in determining prognosis, but are not statistically significant in this study.

Dietary Treatment

Table VIII demonstrates a fairly even distribution between prompt and delayed feedings. Of the 327 patients in this series 127 (38.8%) received immediate feedings, 32 (9.8%) were fed after a 24 hour delay, and 168 (51.4%) after a 48 hour delay. Mortality figures show 6 (31.6%) who were given immediate feedings and 12 (63.2%) who were fed after 48 hours. One patient died a few minutes after hospitalization before treatment could be started. Another patient in whom the diagnosis was not made until autopsy, died of a sudden exsanguinating hemorrhage before feedings could be started. It is our impression that early feedings are probably indicated in patients with bleeding peptic ulcer. From a practical standpoint, the patients with mild hemorrhage tolerate early feedings quite well, while it is obvious that a patient who

is in shock or vomiting cannot be fed. The trend in this hospital has been toward prompt feedings. It is difficult to evaluate the effect of early feeding on mortality rate from this series, because early feeding was deferred in those patients who were in shock, vomiting, or otherwise unable to take food.

### Blood Transfusions

Of 327 cases in this study, 257 (78.3%) received whole blood transfusions. Of those patients with severe hemorrhage (Groups III and IV), 185 (92.5%) received transfusions. The average units (500 cc.) of whole blood given to this group was 4.8 units per patient, while the average units of blood for Groups I and II was 2.4 units per patient. Patients in Groups III and IV who survived received an average of 4.6 units of blood, while those patients in the same groups who died received an average of 6.9 units. One patient who died in Group II was not transfused. This patient was admitted to the hospital for congestive heart failure. Ten days after admission he died from a sudden exsanguinating hemorrhage, shown at autopsy to be due to a bleeding duodenal ulcer. One patient in Group IV who died was not transfused. This patient was in extremis on admission and died before transfusions could be given. It is interesting to note that seven patients in Group I with red blood counts of over 4,000,000 and hemoglobins over 12 gm. received transfusions. (Tables IX and X).

It becomes readily apparent that in this hospital whole blood transfusions were given rather liberally. It is our belief that this liberal use of whole blood transfusions has been a prime factor in attaining a relatively low mortality rate from bleeding peptic ulcers, as shown in this series.

TABLE X  
Effect of transfusions on the death rate

	Group I	Group II	Group III	Group IV	Total
No. Transfused -----	7	65	71	114	257
No. Deaths -----	0	2	5	10	17
% Deaths -----	0	3.1	7.0	8.8	6.6
No. Not Transfused ---	14	41	12	3	70
No. Deaths -----	0	1	0	1	2
% Deaths -----	0	2.4	0	33.3	2.9

TABLE XI  
Mortality

	Total	Medical Treatment	Surgically Treated
No. Cases -----	327	302*	300†
No. Deaths -----	19	16	14
% Deaths -----	5.8	5.3‡	4.7

\* Cases operated on during active bleeding (25) are not included in this column.

† Cases operated on during active bleeding (25) and cases which for one reason or other failed to receive any form of treatment and expired (2) in this column.

‡ This figure probably represents the most acceptable mortality rate for medically treated cases.

### Surgical Treatment

It appears at once (Table XI) that the surgical approach to bleeding peptic ulcer in this hospital has been conservative. In this series of 327 cases of bleeding peptic ulcer, 56 (17.1%) of the patients were operated on. In all, there were 3 surgical deaths, giving an over-all surgical mortality of 5.4%. During the first 24 hours of

TABLE IX  
Units of blood per patient receiving transfusions

	GROUP I			GROUP II			GROUP III			GROUP IV		
	No. Pts.	Units Blood	Units per pt.	No. Pts.	Units Blood	Units per pt.	No. Pts.	Units Blood	Units per pt.	No. Pts.	Units Blood	Units per pt.
Survivors												
Transfused -----	7	7	1	63	154	2.4	66	231	3.5	104	552	5.3
Fatalities												
Transfused -----	0	0	0	2	9	4.5	5	24	4.8	10	79	7.9



TABLE XII  
Surgical intervention

	During Bleeding*					Interval Operation After Cessation of Bleeding
	24 hr.	48 hr.	72 hr.	72 hr. or more	Total	
No. Cases -----	2	0	1	24	27	29
No. Deaths -----	0	0	0	2	2	1
% Deaths -----	0	0	0	8.3	7.0	3.4

\* All of these patients had a gastric resection, with the exception of one, who had a gastroenterostomy. In addition to gastric resection, vagotomy was performed in one patient.

active hemorrhage, only 2 patients were operated upon. None were operated on during the 48 hour period. In the 72 hour period one patient was treated surgically. Twenty-two patients were operated on who had continued bleeding for 72 or more hours. Two patients in this group died (8.3%). The over-all mortality rate for surgery, during active bleeding, was 7.0%. Interval surgery, after bleeding had stopped, shows 29 patients operated on with one death, giving a mortality rate for interval surgery of 3.4%. (Table XII) It is impressive that the highest mortality rate was in those patients operated after 72 hours or more of continued bleeding. It is evident from these figures that early cooperation between physician and surgeon and early decision as to indication for surgery is of utmost importance. When it becomes apparent that a satisfactory red blood count and hemoglobin level cannot be maintained, after 24 to 72 hours of repeated transfusions in a patient with severe, continued hemorrhage from a bleeding peptic ulcer, surgery would seem to be indicated. After 72 hours of continued hemorrhage, the chance of survival seemed to be greater if medical treatment were continued, with special emphasis placed on adequate transfusion of whole blood.

Analysis of Deaths

Table XIII gives a breakdown of the causes of death. In this series of 327 cases there were 19 deaths, resulting in a mortality of 5.8%. The diagnosis was confirmed by autopsy in 14 of the 19 patients who died.

Comment

Comparative studies of mortality rates from bleeding peptic ulcers made in the same community revealed the mortality rate in the Metho-

TABLE XIII  
Analysis of deaths

1. Treated medically -----	16
2. Untreated either because they were moribund on admission and/or the gravity of the situation was not properly evaluated -----	2
3. Surgery during bleeding -----	2
Died on operative table -----	0
Recurrence of bleeding postoperatively -----	1
4. Elective surgery after bleeding stopped -----	1
Recurrence of bleeding -----	0
Postoperative complications unrelated to bleeding -----	2

In 14 of the 19 patients, the diagnosis was confirmed by autopsy.

dist Hospital of Indianapolis, a private hospital, to be considerably lower than in the public hospitals, which included: Indiana University Hospitals, Veterans Administration Hospital, and the Indianapolis General Hospital. It was hoped that some explanation for this difference in therapeutic results would be obtained by analyzing the differences in the two groups. Patients were probably admitted more promptly to the Methodist Hospital and were seen early by staff members, whereas, in the public hospitals patients were seen early by members of the house staff. This suggests that experience and familiarity with this type of case were important factors in determining the final results, despite the fact that the Methodist Hospital has an open staff of over 600 physicians. The liberal use of transfusions in the Methodist Hospital, compared to the somewhat more restricted use of transfusions in some of the public hospitals, was also thought to be an important factor in determining the respective mortality rates. Differences between the surgical mortality rates of the two groups might be explained on the basis of the



relative differences in the time during active hemorrhage when surgery was performed. Also, variation between the two groups in the number of transfusions given prior to surgery may be an important factor.

As a result of this study of 327 cases of bleeding peptic ulcer, we feel that the following criteria are essential if a low mortality from bleeding peptic ulcer is to be achieved:

(1) Proper evaluation of severity of hemorrhage, as determined by the red blood count, hemoglobin, blood pressure, signs of shock, and evaluation relative to the patient's age and number of previous hemorrhages.

(2) Prompt feeding is indicated in the patient with a bleeding peptic ulcer, provided the patient is not in shock, vomiting, or otherwise unable to take food.

(3) The liberal administration of whole blood transfusions is advocated. The mortality rate was definitely higher in those patients with severe hemorrhage who were not adequately transfused. Of those patients in this series who died, almost all had red blood counts under 2,900,000 and hemoglobins under 8.8 gm. These low levels often persisted for several days. Often adequate transfusion of blood was lacking in the therapy of such cases. The patients in this series died, either of exsanguination, per se, or of the complications resulting from prolonged exsanguination and anoxemia.

(4) Early cooperation between the physician and surgeon is all important. When repeated whole blood transfusions fail to maintain satisfactory red blood count and hemoglobin levels in the patient with severe hemorrhage from bleeding peptic ulcer, surgery is indicated. If surgery is performed, it should be within the first 48 to 72 hours of active hemorrhage. After 72 hours, the lowest mortality is achieved by medical treatment, emphasis in this period to be on adequate transfusions of whole blood.

(5) Prognosis of a bleeding peptic ulcer is at all times most difficult. Constant vigilance and

care of the patient with a bleeding peptic ulcer cannot be over emphasized.

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## Case Report:

# AN UNUSUAL BREAST TUMOR

WILLIAM C. REED, M.D.

ANTHONY PIZZO, M.D.\*

*This case is presented because of the unusual size and pathogenesis.*

Mrs. I. F., age 73, came for medical advice because of a severe hemorrhage from an ulcerated area on a huge breast tumor. The patient stated that following the birth of her last child 45 years ago the left breast became indurated, swollen, and tender. After the acute stage of this inflammatory reaction had subsided, a rather hard mass remained, which she referred to as a "weed in the breast." The mass was described as being about the size of a hen's egg, and not painful. The patient had never been examined or had medical advice for the condition.

The patient stated that about 2 years and 7 months prior to our examination on September 11, 1952, she fell striking her left breast against a bed post. She said that she fell with considerable force and that the injury was extremely painful. Immediately following this the left breast became enlarged greatly, turned dark, and her entire anterior chest wall became discolored. After some 6 weeks the chest wall cleared up and the skin returned to normal color, but the breast remained quite large and somewhat lobulated and tense. She still would not seek medical advice, even though urged to do so by the family. The size of the tumor, definitely interfering with the movements of her left arm, was a real burden to her. It was also quite noticeable through her clothing.

The tumor apparently continued to expand, and the skin over the lower pole of the tumor finally became necrotic. About 2 weeks before the examination she suffered a sudden, rather severe hemorrhage from this area, bleeding through her clothing and down onto the floor.

William C. Reed, M.D., Bloomington surgeon, is a graduate of Indiana University School of Medicine where he received his degree in 1920.

Photographs and photomicrographs were furnished by Dr. Pizzo.

Following this episode, she stated that she was willing to see a doctor. She always had maintained the attitude that, "as long as it did not bother her she would not bother it"; but since the hemorrhage, she felt the time had come to do something about it.

At examination a huge tumor of the left breast was revealed. (Fig. 1) It measured 20.3 cm. in its transverse diameter and 30.5 cm. in its vertical diameter. It was irregularly lobulated with one mass projecting up above the left clavicle, another larger lobule projecting anteriorly, and the largest portion of all projecting inferiorly to below the level of the umbilicus. Over the surface of the tumor were several areas of thin, tense, glistening skin bulging above the surrounding surface. The nipple was flattened and presented itself in the lower pole of the tumor. The inferior projecting mass was quite tense; and at its cone-shaped inferior extremity, there was an area of skin necrosis approximately 3 cm. in diameter and covered centrally by a loose crust. There was no hemorrhage from this area at the time of the examination.

Surprisingly enough the huge tumor was not fixed to the anterior chest wall, but could be rotated about its long axis through 30 degrees. Examination of the left axilla was hampered by the overlying tumor, but no definitely enlarged nodes were palpated. Since the tumor was not fixed and no axillary nodes were felt, it was believed that the tumor could be successfully removed. Her blood pressure, heart and lungs, blood studies, and urine examinations were all

\* Pathologist, Bloomington Hospital and Dunn Memorial Hospital, Bedford.



Figure 1. Breast tumor before surgery.

well within normal limits for a woman of 73 years of age.

Under I-V sodium pentothal and nitrous oxide inhalation anesthesia, skin flaps were fashioned which would allow closure of the wound without tension and which would also eliminate areas of skin necrosis and degeneration. The mass was excised from the upper abdominal and anterior chest wall without too much difficulty. The entire mass having been removed, a good view of the axilla was obtained and palpable lymph nodes were discovered. The axilla was therefore cleaned out. The skin flaps were approximated without tension, and a penrose drain was inserted in the most dependent portion of the wound. (Fig. 2) Dressings were held in place and compression of the wound was secured by use of a 6 inch Tensor bandage.

The wound healed without infection and the black silk skin sutures were removed the third postoperative day. The patient made an uneventful recovery. She was up in a chair the day following surgery, and she was able to leave the hospital on the sixth postoperative day.

### Pathology Report

Grossly the specimen was a large, hard, irregularly nodular and focally fluctuant tumor measuring 20.3 cm x 30.5 cm x 23 cm. It was covered on one side by white skin measuring 22 cm x 21 cm in average dimensions. A flattened but still slightly everted nipple was located 4 cm from one of the cut edges. Five cm lateral to the nipple, there was an area of dark tan discoloration measuring 3 cm in diameter. This area contained a small centrally located crusted ulcer-

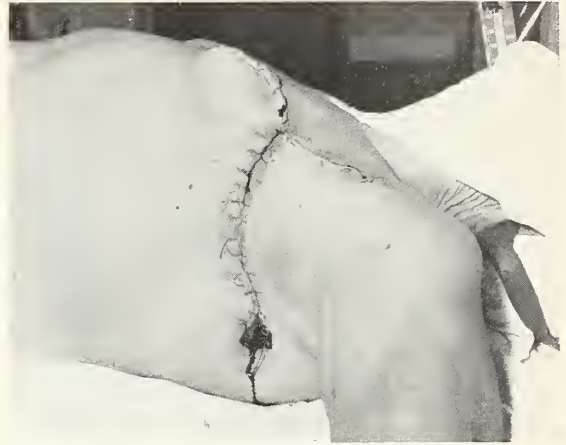


Figure 2. Resulting skin closure.

ation which measured 0.8 cm in diameter. The remainder of the tumor was covered by a dense, shaggy tan fibrous capsule. As the tumor was opened a large amount of thin dark brown fluid escaped under considerable pressure. On further sectioning, the tumor was found to be composed of a large cyst which contained in addition to the above described fluid, an estimated 1000 cc of old blood clots. The cyst lining was shaggy, dark brown and focally contained adherent blood clots. Also present were numerous slightly firm polypoid tumors extending into the lumen. (Fig. 3) Most of these tumors arose from the anterior portion of the cyst although several were widely separated. They measured from 1 cm to 3 cm in diameter, were nodular, and were covered by a smooth glistening surface. On cut section these tumors were friable and the surfaces were fairly uniform, slightly translucent and pink in color. The cyst wall measured 0.3 cm in aver-

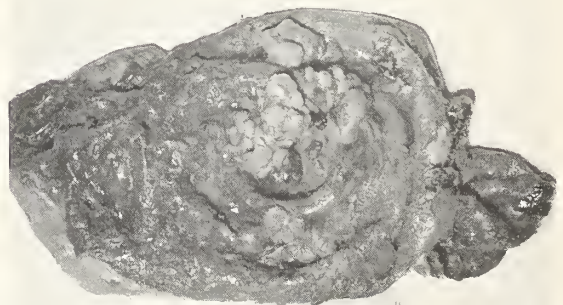


Figure 3. Cystic tumor evacuated.  
Note papillary tumors.



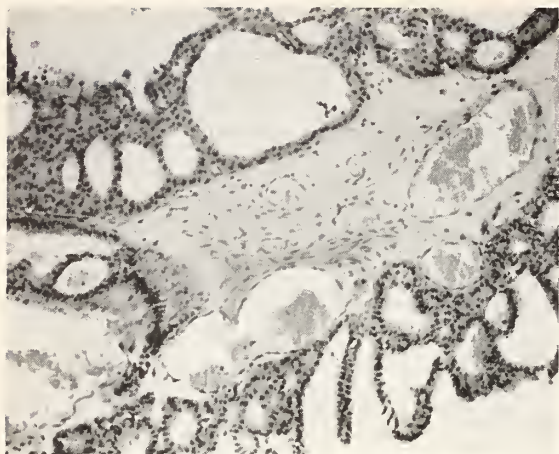


Figure 4. Photomicrograph of typical section of the tumor. Notice thin-walled superficial blood vessels. (H&E x 60).

age thickness and in the region of the above described tumors was grossly intact. In the region of the nipple there was a small amount of atrophic breast tissue. Also received were two irregular fragments of adipose tissue, from which six lymph nodes were dissected free.

Microscopically the sections through several of the tumors were similar. (Fig. 4) They were composed of thin, branching fibrous tissue cores covered by a simple moderately tall columnar epithelium. These epithelial cells were fairly uniform and contained distinct cellular outlines and a copious, granular, faintly eosinophilic cytoplasm. The nuclei were ovoid to fusiform and normachromatic. However, a few hyperchromatic nuclei with clumping of the chromatin were noted. Mitoses were infrequent. The cyst wall itself was composed of dense hyalinized connective tissues containing scattered collections of small round cells as well as areas of recent and old hemorrhage. No separate islands of tumor tissue were noted in this wall. Only one of the lymph nodes was remarkable. (Fig. 5) This contained a small island of tumor tissue histologically identical with that described above.

### Diagnosis

Well-differentiated papillary adenocarcinoma of breast with metastasis to one of six lymph nodes.

### Discussion

Both clinically and morphologically it is probable that this tumor was initially an intraductal papilloma. Although biologically variable it is not likely that a malignancy had been present for 45 years. Most intraductal papillomas are asso-

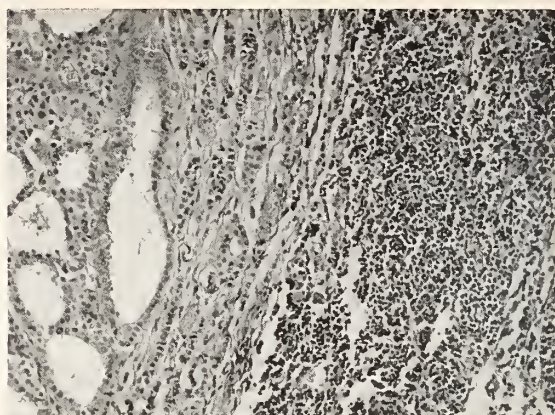


Figure 5. Photomicrograph of axillary lymph node metastasis. Morphology identical to primary above. (H&E x 150).

ciated with bleeding and cyst formation. In this case the trauma approximately two and one half years previous to surgery apparently induced considerable bleeding, which resulted in massive size and eventual rupture.

Intraductal papillomas occur predominantly in parous women at or shortly before the menopause. However, there are frequent exceptions. It has been variously estimated that from 5% to 25% of these lesions are malignant when removed. Papillary adenocarcinomas of the breast constitute an estimated 5% of all breast malignancies, occurring mainly in the 35-40 age group. They typically grow slowly and metastasize relatively late.

### Summary

1. A case report of an unusual breast tumor is presented.
2. It supports the contention that intraductal papillomas should be considered potentially malignant.
3. It also illustrates the necessity of removing all breast tumors as soon as they are discovered.

### Addendum:

The patient was completely well for approximately eight months following surgery. In May 1953 she developed ankle edema. This gradually progressed until she had marked ascites and pleural effusion. Roentgenogram of thorax and abdomen was done on July 9, 1953. The significant changes were those due to pleural effusion, ascites, enlargement of hilar lymph nodes, and enlargement of the liver. Three weeks prior to her death she began to have hematemesis and tarry stools. She died on August 6, 1953. Post-mortem examination was not permitted.



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## ACCEPTABLE DIATHERMY APPARATUS

PHYSICIANS are reminded of the rules of the Federal Communications Commission in regard to wave lengths of medical diathermy equipment. The effective date for compliance was June 30, 1953. Since that time all equipment operating on frequencies outside those prescribed are in violation of the rule. The authorized channels are 13,560 kilocycles plus or minus 6.78 kilocycles, 27,120 kilocycles plus or

minus 160 kilocycles, and 40,680 kilocycles plus or minus 20 kilocycles. Accepted forms of diathermy apparatus are listed in a booklet entitled "Apparatus Accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association". This booklet may be inspected at the Headquarters Office of the ISMA, or may be obtained by writing the Council on Physical Medicine and Rehabilitation of the A.M.A.

## MENTAL HEALTH IN CIVILIAN EMERGENCIES

THE U. S. PUBLIC HEALTH SERVICE has published a pamphlet\* on the subject of mental health in emergencies. While it was written primarily to aid those who are planning for civil defense against atomic bombing, it is applicable to the problems of smaller, though nevertheless large scale, natural disasters.

As is pointed out in the foreword, there are

no pat solutions to this problem. The pamphlet avoids any attempt at suggesting pat solutions. It does state basic principles, and lists many questions which are intended to serve as a guide or check list for the intricate planning in this field.

Three significant points are used to introduce the subject:

1. Planning for psychological aspects is as important as planning for physical welfare.

2. Fear and excitement will result in irrational behavior if planning is faulty.

3. People develop capacity to cope with emergencies only by becoming emotionally and psychologically involved in studying the facts and making individual decisions as to their roles in disaster.

"The possibility of panic in a population will be minimized if the people are well informed on what to expect, if they have confidence in their leaders and in the civil defense plans that have been developed, and if they know what to do and have had an opportunity to rehearse their part in the civil defense plan."

It is well known that when an individual has something to do in time of personal danger apprehension is at a minimum. Athletes know that the pre-game tension, which may be so pronounced as to interfere with muscular coordination, disappears after the game is actually under way.

This is a principle which must be utilized in the control and prevention of panic. When it has been fully utilized every adult, and even children old enough to assume some household task, will

know what they are to do in event of a catastrophe.

The block system of civilian organization, used in England for civil defense in World War II, is ideal for accomplishing mass education of this type. When each neighborhood is organized, and when each family group is organized within itself, tasks for rescue, first aid, emergency feeding and emergency housing will supply everyone with a responsibility. Each person under this plan will know that if he is injured he will be cared for; and if he is not injured he will know what his part in the overall picture will be.

Public education in civil defense has tended to outline the dangers and magnify the problems of atomic disasters. It has not, up to this point, afforded adequate opportunities for people to talk out the problems. Small group discussions and small group planning in the neighborhood or in block organizations will offer this opportunity. It will quiet unreasonable apprehensions and allow practical planning. It is the best plan for prevention of panic.

\* "Mental Health Implications in Civilian Emergencies", U. S. Department of Health, Education and Welfare. Copies are available from Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Price 15 cents.

## GERIATRICS—MEDICAL OPPORTUNITY

**T**HIS NATION is the most favored nation on the face of the earth today. Its wealth is tremendous. Its people are relatively free, and its lands have not been destroyed by the invading hand. As a nation, we have been profligate of our great natural resources in the past. At present we are extremely profligate of our human resources. The economic usefulness of some 10,000,000 people is discarded at age sixty-five, and the burden of their support is in large measure placed upon those in a younger age group who are economically productive. The individual is taught from early life to think of retirement and pension, rather than to think in terms of continued usefulness as long as he lives. We destroy 40,000 people annually on our highways.

We are in ideological conflict with opponents who have unlimited manpower, whose citizens

have great mental capacity, whose people are capable of great scientific achievement, and whose leaders are dedicated to the objective of world domination. If we are to meet our adversaries successfully, we need to conserve our total human resource.

Society, in general, must provide youth with unlimited challenge; it must present youth with great opportunity and the mental, physical and emotional capacity of our young people must be developed to the utmost. In our social structure, citizens with mature minds must be motivated to work to their greatest capacity, and must be allowed to work unhampered by economic restriction, blind prejudice or consuming envy.

The increasing median age of our citizens, the fact that there are approximately 15,000,000 of our people in the over-sixty age group, and the knowledge that the average life expectancy is

now approaching seventy years, emphasizes to us the importance of the geriatric problem in our economic and social structure. Necessity suggests that we keep this older age group economically useful. We are short in manpower as compared to our ideological opponents.

The foundations for senescence are laid in the years of youth and maturity. The peak incidence of chronic disease occurs in the two decades between thirty-five to fifty-four years, while the peak incidence of disablement and invalidism is found in the period from fifty-five to seventy-four years of age. The person who develops good mental habits, excellent emotional attitudes and useful physical skills in youth, who keeps the mind alert by continued study, the body strong and supple by proper nutrition and physical activity, and the spirit fed by "faith, hope and charity" during maturity, will often remain useful and alert, and an important member of our society during his waning years. It is important for this individual to know that society appreciates his abilities, and is eager to use them as long as they exist.

The physician is in a key position to aid in the social conservation of those people who have reached maturity, and are mellowing with age. Knowledge, now existent, can be applied more

effectively to the fields of nutrition. We are well, but not wisely, fed in this nation. Much remains to be done in guiding our eating habits as a nation. Existing information provides a foundation for better work in prevention and treatment of such diseases as obesity, myxedema, primary and secondary anemia, diabetes and malnutrition, cancer, and tuberculosis. The prevention of accidents and sound public instruction in the matter of alcoholic abuse will yield large human dividends. Much can be done to guide social attitudes in regard to aging, and to motivate the individual to remain useful as long as he lives.

The problem of chronic disease and its resultant invalidism has been spoken of as "medicine's number one problem." Research and practice in this field will enable the physician to make a notable contribution in the conservation and wise utilization of our greatest national resource, its human resource.

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W. S. N.

—*Minnesota Medicine*.



# The President's Page

FELLOW MEMBERS OF I.S.M.A.:

THE INTERIM SESSION of the American Medical Association met in St. Louis on December 1. It was my pleasure to attend this meeting as well as the National Blue Shield Commission meeting which was held just prior to the A. M. A. Indiana was well represented; in addition to the delegates and their alternates a large number of physicians attended.

The chief interest of the Indiana group was the resolution concerning Accreditation of Hospitals which was introduced at the Indiana State Medical Association convention last fall. There was a great deal of misunderstanding and many problems regarding the resolution requesting that a series of checks and balances be set up. We found that there were several methods already in existence by which we thought the intent of the request could be accomplished and could devise no further methods.

We had meetings with the members of the Accreditation Board, the Council of Medical Education and Hospitals and were able to clear up several of our points.

We understood that:

1. The Staff of a Hospital which has not been accredited can appeal from the ruling of the examiner to the full board or a sub-committee thereof.
2. They can appeal to the standing Committee on Medical Education and Hospitals of the Indiana State Medical Association which will refer it to the same committee of the American Medical Association.
3. The County Society can pass a resolution to the Indiana State Medical Association House of Delegates to have our delegates carry it to the American Medical Association House of Delegates.
4. That hospitals are not accredited for interns and residents by the Accreditation Committee but by the Council on Medical Education and Hospitals of the American Medical Association. Thus a hospital can be accredited by the Board and not be eligible for interns, etc. unless O.K.'d by the American Medical Association.
5. That the general practitioner will be able to send cases to hospitals and attend them in any of the departments in which he is qualified by the local hospital.

The delegates and the group present felt there was need for further clarification and introduced the following resolution which was passed by the House of Delegates:

**"Resolved,** That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in The Journal of the American Medical Association and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, bylaws and their interpretations: and be it further

**"Resolved,** That the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement.

*Wm Harry Howard M.D*

# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

Dear Hoosier Doctors:

Beginning with this issue of *THE JOURNAL* your medical association is allowing the Auxiliary additional space in the publication, and we are hoping that through this new acquaintanceship we will be able to perfect a better working arrangement between the county medical societies and their auxiliaries. The auxiliary was organized some 26 years ago with its prime purpose to assist the medical society at its direction and to promote a friendlier relationship between physicians' families; yet even today it is unfortunate that many county medical societies and the physician members do not understand the objects and the aims of their auxiliary. Over the years the auxiliary has slowly but steadily grown until today it has a membership exceeding 2,300, and through the combined efforts of these members much is accomplished in Indiana over each yearly period. This was much in evidence when Mrs. Hubert T. Goodman, Terre Haute, immediate past president, gave her yearly report for 1952-53 last June at the national convention which was held in New York.

To give a brief resume of the net results of Hoosier Doctors' Wives working together, we point to some of the highlights from this report which clearly reveal that much can be accomplished when all those concerned are working toward the same goal. There was active participation in annual preschool round-ups, school immunization programs and diabetic detection clinics. The Auxiliary presented four regional health conferences (12 counties participated), staffed booths at county fairs, and members staffed the booth at the Indiana State Fair for the local medical society. They volunteered their services for fund drives of the Red Cross, Community Chest, heart association, tuberculosis and cancer societies, polio foundation, crippled children's society and mental health association. Members worked in hospitals in various capacities, and staffed heart kitchen, mobile blood and x-ray units. One county collected 10,000 pounds of sample drugs for distribution to indigent patients at a general hospital and to provide interns with an opportunity to use new and

costly drugs in treatment. One county working with its county medical society presented a TV set to the women of the county farm.

Nurse Recruitment—there were many teas held for prospective student nurses, pertinent films were shown, educational meetings held and many members participated in school guidance programs. Scholarships, gifts, and loan funds numbered 39, with grants varying from \$25 to \$400. One Auxiliary sponsored a postgraduate course in polio treatment for a graduate nurse. Six student nurses received partial gift scholarships. One Auxiliary presented useful gifts for their quarters to student nurses who are in training in a mental hospital. At state level the auxiliary awarded for the past two years a \$100 4-H nursing scholarship. One auxiliary has been designated to administer nursing scholarships for the county medical society and the local cancer society. Sponsorship of 21 Future Nurses Clubs in high schools of Indiana has been reported after this project was added to the agenda.

Civil Defense is presented at county level. Twenty counties listed interest and activity.

Legislation was in the foreground and continues to be very important. Copies of *I.L.O. Spells Danger* were distributed to all counties. A resolution to the Auxiliary House of Delegates favoring legislation along the lines of the Bricker Resolution was presented and passed.

*Today's Health* subscriptions showed an increase over last year, but our record is still not that usually achieved by Indiana. Many auxiliaries alone, and with assistance of their county medical societies, presented gift subscriptions to schools, libraries, beauty and barber shops, Y.M.C.A.'s and Y.W.C.A.'s, social service agencies, and clubs.

Our A.M.E.F. chairman spared no effort to achieve the objective of "Every Auxiliary a Contributor". Indiana reported \$1,681.11 for the American Medical Education Foundation.

Sincerely,

Sue Matthew (Mrs. W. Burleigh)  
President, Woman's Auxiliary,  
Indiana State Medical Association

## A. M. A. Washington Office News

**15-Man Hoover Medical Task Force Completed: Has 13 M.D.'S.** The announcement of 12 more appointments completes the membership of the Hoover Commission task force on medical services. Earlier the commission named Mr. Chauncey McCormick, Chicago businessman, as chairman, and Dr. Edwin I. Crosby, also of Chicago, as research director.\* The third appointment announced earlier was that of Dr. Walter Martin, president-elect of the American Medical Association.

The following have accepted appointment to the remaining posts: *Dr. Francis J. Braceland*, dean, Loyola (Chicago) University School of Medicine, naval reserve captain, member Armed Forces Medical Advisory Committee; *Dr. Edward Delos Churchill*, chief of general surgical service, Massachusetts General Hospital, medical veteran both World Wars, member medical task force of first Hoover Commission; *Dr. Michael DeBakey*, professor of surgery and chairman of department of surgery, Baylor University College of Medicine, Army medical officer in World War II, member medical task force of first Hoover Commission; *Dr. Everts A. Graham*, surgeon-in-chief, Barnes Hospital and St. Louis Children's Hospital, medical veteran of World War I; *Dr. Alan Gregg*, vice president of Rockefeller Foundation, medical veteran of World War I, member Health Resources Advisory Committee, ODM; *Dr. Paul R. Hawley*, retired regular Army major general, director American College of Surgeons, former chief medical director, Veterans Administration; *Dr. Theodore George Klumpp*, president, Winthrop-Stearns, Inc., N. Y., and Winthrop Products, Inc., N. J.; *Dr. Hugh Rodman Leavall*, professor of public health practice, Harvard School of Public Health, member medical task force of first Hoover Commission; *Dr. Basil C. MacLean*, director, Strong Memorial Hospital and professor of hospital administration at University of Rochester, Army medical officer in World War II, consultant to medical task force of first Hoover Commission; *Dr. James Roscoe Miller*, president of Northwestern University, Army and Navy service in World War II; *Dr. Milton C. Winternitz*, chairman, division of medical sciences of National Research Council, Army medical officer in World War I; *Dr. Otto W. Brandhorst*, dean of Washington University (St. Louis) School of Dentistry.

The task force will study operations of all federal medical programs, including Veterans Administration and the military, and will recommend possible consolidations. Officially the commission is known as the Commission on Organization of the Executive Branch of the Government. The first Hoover Commission proposed, among other medical changes, that all federal medical services be grouped under a United Medical Administration. The plan was defeated in Congress.

**No Doctor Draft Needed After 1955, U.S. Officials Agree.** Present Defense Department planning envisions no extension of the doctor draft beyond July 1, 1955, but instead it calls for a program of "fence mending" and "belt tightening," federal officials concerned with the law stated at the annual meeting of the Association of Military Surgeons. This position was outlined at the same time that *Dr. Edward J. McCormick*, president of the American Medical Association, told the surgeons: "It is our belief that this is a most propitious time for devising a program which will clearly eliminate any need for this legislation well in advance of July 1, 1955."



*Dr. Melvin A. Casberg*, Assistant Secretary of Defense (Health and Medical), said steps taken or planned to stimulate regular medical officer procurement include study of a law to provide medical scholarships to students commissioned in the armed forces following graduation. He said, however, that this will create a problem: "All Indians and no chiefs." It is the duty of civilian organizations, he said, to aid the military in procuring more experienced doctors for teaching and training posts in the services.

*Dr. Howard A. Rusk*, chairman of the Health Resources Advisory Committee, recommended a further reduction in the physician-troop ratio, from a projected 3.2 to 2.9, as one form of belt tightening. If the size of the armed forces doesn't increase, he believes it should be possible to meet requirements after mid-1955 from each year's graduating classes. In the meantime, however, drafting of doctors will resume late next summer or early fall, he said, with possibility that as many as 1,250 Priority III doctors in their early 30s will have to be called during the life of the act.

Dr. McCormick also made these points: (1) the problem of medical care for military dependents should be turned over for study to the Hoover Commission on government reorganization, with final determinations by Congress, (2) meanwhile there should be improved utilization of military medical personnel and curtailment in non-professional duties, (3) in the event a universal military training program is voted, then pre-professional and professional education for qualified students should be continued.

**John W. Tramburg of Wisconsin Heads Social Security Administration.** John W. Tramburg, a 40-year old Wisconsin Republican is the new administrator of the Federal Social Security Administration. He is chairman of the Council of State Public Assistance and Welfare Administrators and since 1950 has been director of the Wisconsin Department of Public Welfare. The social security post has been vacant since the resignation earlier this year of Arthur J. Altmeyer. Mr. Tramburg will serve on an interim presidential appointment until the Senate acts on his nomination.

Mr. Tramburg will be responsible for the Bureau of Old Age and Survivors Insurance, the biggest (\$1.4 billion) operation in the Department of Health, Education, and Welfare. All but a fraction of the funds go for grants to states for OASI payments, and crippled children and public assistance programs.

Pending in Congress is an administration recommendation that OASI be extended to 10 million more persons, including physicians. If Congress should enact such controversial laws as free hospitalization for the aged, waiver of OASI premiums for disability, or permanent and total disability pensions, they would also be administered by Mr. Tramburg's agency. These proposals have been made in the past, but have been defeated each time by Congress.

**Military Group Recommends More Dependent Medical Care.** A 5-man committee of admirals and generals named by the Secretary of Defense last spring believes that a serious deterioration of career service can be halted only by such things as higher military pay and more medical and dental care for dependents. The report was made public a day after Assistant Secretary of Defense John Hammah warned that the services were losing career men in numbers "so great as to be disturbing." He, too, cited low military pay and a "continual nibbling away at fringe benefits."

The study group, headed by Rear Admiral J. P. Womble, Jr., put the blame for decline in fringe benefits on "pressure groups of business interests" and "congressional economy attacks."

The report said benefits must be fully restored, must be declared by law to be a part of service pay, and in some cases must be increased. It defined benefits as hazardous and incentive duty pay, sea and foreign duty pay, medical and dental care for dependents, better and cheaper housing, and better provision for education of service children.

In making the report public, Mr. Hannah said it would receive careful consideration from the military services, the Defense Department and the Joint Chiefs of Staff. He added that its release did not imply "approval or acceptance" by the department "in every respect."

**Waiver of OASI Premium for Disability Under Study in DHEW.** The administration has under "continuing study" a proposal to freeze Old Age and Survivors Insurance for totally disabled workers. The plan would provide that at age 65 a disabled worker's benefits would not be reduced because of his non-working years resulting from the disablement. This is similar to the waiver of premium proposal which the American Medical Association opposed in the 82nd Congress because, among other things, it granted final authority in medical determination to the federal government (then the Federal Security Administrator). The AMA has proposed instead that OASI payments to the totally disabled be based on their 10 best working years, thus obviating the need for medical determination in most cases.

The question was raised during the first week of the social security fact-finding hearings of the House Ways and Means subcommittee, headed by Rep. Carl Curtis (R., Neb.). Robert M. Ball, acting head of the Bureau of OASI in the Department of Health, Education, and Welfare, stressed that no firm policy had been adopted by HEW on waiver of premium but that it was under study. He estimated that implementation of the freeze of waiver of premium would cost .05% of present payroll receipts to the OASI fund.

Mr. Ball also supplied the committee with figures showing that by 1980 the number of persons over 65 either receiving OASI benefits or eligible would rise to 18,240,000, compared with 4,100,000 at the end of 1952. This is an increase of 450%.

In earlier testimony, Phillip Hughes, assistant chief of the Budget Bureau's labor and welfare division, estimated that non-service-connected disability pensions to veterans may reach \$3,297,000,000 by 1985, compared with \$430,000,000 this year, an increase of 750%. He said he believed that half of those who have OASI coverage are also potential beneficiaries under the veterans' benefits programs. (Total annual VA payments to all veterans of around \$2.5 billion are about equal to OASI payments.)

**Defense Department's Scholarship Legislation is About Ready.** Defense Department's draft legislation for medical and other federal scholarships is receiving a final checking over before presentation to the Budget Bureau for approval. Budget Bureau approval is necessary if the plan is to be presented as an administration bill, but regardless of the bureau's action, the proposal could be offered by any member of House or Senate. Essential provisions of the plan:

1. Any medical, dental, nursing, or veterinary student accepting a scholarship would be obligated for one year of federal service for each scholarship year.
2. Payment would be made directly to the schools for tuition and other incidentals and to the student to cover living expenses during the school year.
3. Scholarships, limited to four years, would not be offered to pre-medical students or others preparing for professional courses.
4. Deans would make recommendations, but final selection would be by the Defense Department.

According to a department spokesman, there are two objectives: First, to meet armed forces needs after expiration of the doctor draft in 1955, if the regular draft obligation does not produce enough officers. Second, to interest enough young officers in regular military careers to maintain the regular corps at the necessary level. Currently regular medical officers make up only about 25% of the medical corps total; it is hoped to reverse this ratio.

# THE INCUBATOR LOAN PROGRAM IN INDIANA

JEANNE E. RYBOLT, M.D.\*

*Indianapolis*

## THE PROBLEM

**P**REMATURITY is recognized as a health problem of national magnitude. In Indiana in 1951, almost half (47.3 per cent, to be exact) of the infants who died under one year of age had prematurity recorded on the death certificate as the primary or contributory cause of death. This meant that 1,328 babies were lost in our state in that year because of prematurity alone or because prematurity contributed to the infant's death.

## BACKGROUND

Almost 15 years ago, the Committee on Maternal and Child Health of the Indiana State Medical Association in conjunction with the Bureau of Maternal and Child Health of the Indiana State Board of Health recognized prematurity as a problem of major concern in the State of Indiana. In attempting to reduce mortality in premature infants, this group established a three point program:

1. Increasing efforts to prevent premature birth.
2. Disseminating knowledge of and facilities for the special care needed by premature infants.
3. Increasing our knowledge of the premature problem by engaging in research.

In the late 1930's the director of the Bureau of Maternal and Child Health, Dr. Howard Mettel, established the first incubator loan program in Indiana. Dr. Mettel and engineers from Purdue University designed plans for a simple wooden, box-like incubator that could be built by carpenters or high school shop pupils in local communities. During this time Indiana was

Jeanne E. Rybolt, M.D., is a 1951 graduate of the Indiana University School of Medicine. She served a joint internship at Seaside Memorial Hospital, Long Beach, California, and at Los Angeles County Hospital. Dr. Rybolt has been with the Indiana State Board of Health since July, 1952.



divided into district health departments; one wooden incubator, built from the Purdue plans, was sent to each district health department for lending purposes. This gave opportunity for all areas in the state to have access to the use of an incubator. In addition, the plans for these original incubators were sent to each county and, from these, many communities built their own incubators in order to have them available for the care and transportation of premature infants. These incubators were simple in design and easy to construct, and although they appear crude today, they were a progressive step in the care of premature infants in Indiana.

That was in the late 1930's; then, as time passed, and the war came and went, better incubators were developed. It was found that the original incubators with their primitive method of regulating heat and humidity were unsafe in some instances. The Indiana State Board of Health and the Maternal and Child Health Committee felt that the old wooden incubators should be replaced with a newer, safer type.

Modern incubators were purchased by the State Board of Health, and placed in incubator loan centers. Three methods were used in the establishment of such centers. First, the old wooden incubators, distributed to the district health departments were replaced; and, although there were insufficient numbers of new incubators to substitute for all those that had been built in local communities, according to the Purdue plans, it was suggested that those home-made incubators be destroyed. Should need for

\* Acting Director, Division of Maternal and Child Health, Indiana State Board of Health.



an incubator arise, a request could be made to the loan center in that area. Next, each full-time health department was contacted with the suggestion that an incubator loan center be established; and, finally local communities were asked to set up a loan center whenever the need seemed to warrant it.

As these centers were being established, the Maternal and Child Health Committee of the Indiana State Medical Association helped with the development of policies and procedures for the loan of incubators and also assisted in the writing of material on premature infant care. This information has been published in the Indiana State Medical Journal and will be distributed to the secretary of each local medical society and to every hospital in Indiana having a department of obstetrics.

The Committee on Maternal and Child Health from the Indiana State Medical Association has suggested that the Maternal and Child Health Program of the State Board of Health place major emphasis on the prevention and care of prematurity. Concurrent with this, six premature institutes have been held in different areas in the state during the past year; these institutes have been sponsored by the Indiana League for Nursing, the Indiana State Medical Association and the Indiana State Board of Health and are a part of the effort to reduce premature morbidity and mortality.

As statistics were examined prior to the establishment of loan centers, some interesting facts were found. First, contrary to our belief, Lake and Marion Counties have the majority of the home deliveries in the state. As was expected, there are more premature infants delivered in these counties because Lake and Marion Counties are the most populous counties in Indiana. Therefore, more incubators have been placed in the loan centers in these two counties. Secondly, in 1940, only half of the deliveries occurred in hospitals in the state, but in 1952 almost 94 per cent of the babies born in Indiana were delivered in hospitals. So, although some incubators will be used in homes, the majority will be loaned to small hospitals that cannot afford to equip themselves for an unusual number of premature infants; this differentiates the present program from that established originally.

## LOAN CENTERS

As the incubator loan centers have been established, two requirements have been made by the Indiana State Board of Health. First, the attending physician is the only person who can request the loan of an incubator for his patient, and he may obtain the incubator by calling the loan center in his area; if the incubators in that center are in use, one may be obtained from the Division of Maternal and Child Health of the Indiana State Board of Health. Also, a report must be submitted every three months for each incubator that has been placed by the State Board of Health in a loan center; this report tells how much the incubator has been used during the previous three-month period.

Incubator loan centers in Indiana are as follows:

### Already in Operation

#### Brown County

Brown County Health Department, Nashville

#### Clark County

Clark County Memorial Hospital,  
Jeffersonville

#### Delaware County

Ball Memorial Hospital, Muncie

#### Fayette County

Fayette Memorial Hospital, Connersville

#### Floyd County

Floyd County Memorial Hospital,  
New Albany

#### Kosciusko County

Kosciusko County Health Department,  
Warsaw

#### Lake County

Gary Health Department, Gary  
Hammond Health Department, Hammond

#### Marion County

General Hospital, Indianapolis  
Indiana State Board of Health, Indianapolis  
Methodist Hospital, Indianapolis

#### Noble County

Luckey Hospital, Wolflake  
McCray Memorial Hospital, Kendallville

#### Vigo County

Union Hospital, Terre Haute

The incubator loan program in Indiana is an example of the cooperation of official and voluntary agencies, professional groups, social individuals. Through such concerted effort, the waste of infant lives caused by prematurity can be reduced.

## ON-THE-SCENE REPORT MADE OF A.M.A. CLINICAL SESSION: HOUSE SETS POLICIES

**T**HE HOUSE OF DELEGATES of the American Medical Association, meeting at the Jefferson Hotel in St. Louis during the Seventh Annual Clinical Session took important policy actions on social security, voluntary health insurance, medical ethics and unethical practices, medical education, hospital accreditation, military affairs and a wide variety of subjects affecting both physicians and the public.

Highlight of the opening House session on Tuesday was the announcement that Dr. Joseph I. Greenwell of New Haven, Kentucky, had been selected by a special committee of the A.M.A. Board of Trustees as the 1953 "General Practitioner of the Year." The annual medal and citation for community service by a family physician were presented to Dr. Greenwell by Dr. Edward J. McCormick of Toledo, Ohio, President of the American Medical Association, who also addressed the opening session.

The Tuesday program also included addresses by Dr. James R. Reuling of Bayside, New York, Speaker of the House of Delegates, and Dr. Chester Keefer of Boston, Special Assistant to Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare. Annual reports were presented by Dr. George F. Lull, Secretary and General Manager of the A.M.A.; Dr. Dwight H. Murray of Napa California, Chairman of the Board of Trustees, and by the standing and special committees of the House of Delegates.

Approving a recommendation by its Reference Committee on Legislation and Public Relations, the House passed a resolution reaffirming its opposition to the compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act and advocating passage of the Jenkins-Keogh bills now pending in Congress. These bills were described as providing for "the development of a voluntary pension program which is equitable,

free from compulsion, and satisfies the retirement needs of physicians."

The reference committee report adopted by the House said:

"The purpose of these bills is to eliminate the discrimination, and inequities which exist under present tax laws by extending the tax deferment privilege to the country's ten million self-employed and also to millions of employees who are not covered by pension plans. The purpose of the resolution is to reaffirm our support of the voluntary pension program provided in the Jenkins-Keogh bills and to reaffirm our strong opposition to the extension of compulsory coverage of physicians and other self-employed persons under Title II of the Social Security Act."

### Push Bricker Amendment

The same committee report urged continued action to obtain passage of the Bricker Amendment (S.J. Res. 1) and approved the principle of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes. It also opposed any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955.

The report said that "your Committee feels strongly that there should be no further extension of the 'Doctor Draft' Law. We feel that the legislation is discriminatory and urge the Committee on Legislation and the Board of Trustees to actively oppose any further extension."

The House acted to accelerate the development of voluntary health insurance by passing a resolution requesting the Council on Medical Service to proceed immediately with a special study of the problems of catastrophic coverage and coverage for retired persons. The Council was asked to present its findings and recommendations to the House not later than the 1954 Clinical Meeting. The resolution pointed out:

"There are two large groups of citizens for



# The Problem of Nausea and Vomiting:

## ITS TREATMENT WITH DRAMAMINE®

Whenever nausea, vomiting and vertigo are disturbing and complicating factors, Dramamine may be used with confidence.

Keats<sup>1</sup> outlines the wide list of conditions in which Dramamine (brand of dimenhydrinate) has proved valuable as follows: "It has been well established in the control of motion sickness. It has been used effectively in the prevention and treatment of seasickness, airsickness, [in the treatment of] the nausea of pregnancy, Ménière's syndrome, . . . radiation sickness . . . and postfenestration reactions. . . . The site of action is imperfectly understood, but there is indication of an action of depressing labyrinthine function or its neural pathways, a highly selective central action, or both. Few side reactions of this drug have been noted."

The usual dose for motion sickness is 50 mg. (one tablet) taken one-half hour before departure and, if necessary, before meals for the duration of the journey. Control of nausea and vomiting of other conditions and severe motion sickness is achieved, with minimal drowsiness, by a dosage of 100 mg. every four hours.

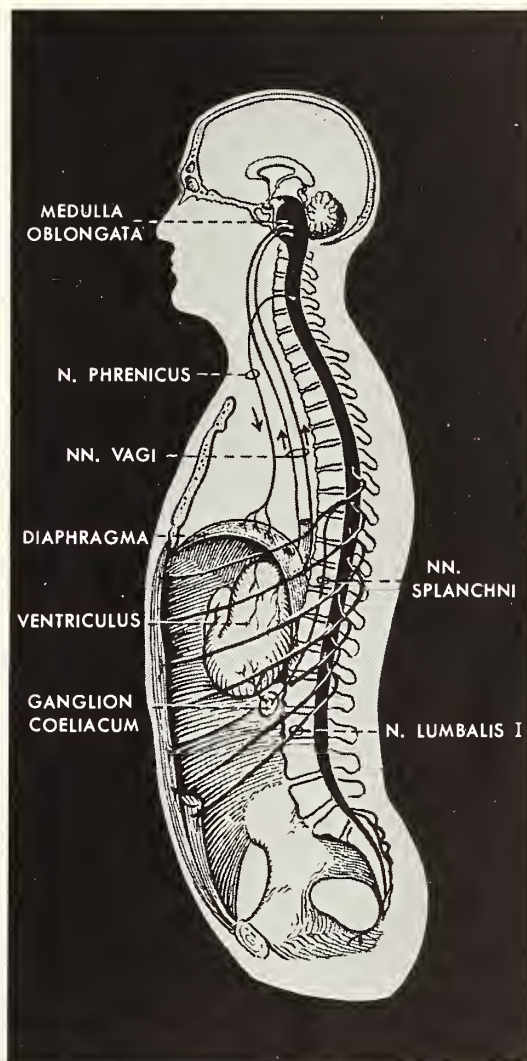
"[Dramamine] is administered orally or rectally. . . . The same doses may be administered rectally by insertion of the tablet or other suitable form. . . ."

Dramamine Liquid is particularly useful for children.

Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Keats, S.: Ataxic Cerebral Palsy with Akimetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey 50:53 (Feb.) 1953.

2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, 1953, p. 471.



THE VOMITING REFLEX: *Vagus*→*nodose ganglion*→*solitary tract*→*spinal cord*→*cervical, thoracic and lumbar nerves* to *diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature*. (After Krieg, W. J. S.: *Functional Neuroanatomy*, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)

SEARLE Research in the Service of Medicine

whom improved coverage could be offered under present prepaid medical care plans, namely: (a) those individuals who suffer catastrophic or long-continued and highly expensive illness and whose financial resources are not adequate to meet the cost thereof and (b) those citizens who have retired and are living on small incomes and who are not eligible under presently existing public or private plans."

The resolution emphasized the medical profession's "responsibility to make every effort to promote such prepaid medical coverage for all citizens whose circumstances make them eligible."

Another resolution on voluntary health insurance, adjudged to be emergency business by the Reference Committee on Insurance and Medical Service and then passed by the House, stated that "the American Medical Association condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirmed previous actions of the House defining pathology, radiology, anesthesiology and psychiatry as medical services.

### Referred for Study

A second emergency resolution, which would have endorsed the principle of federally subsidized scholarships for prospective military personnel in order to encourage the building up of a career-basis medical corps for the armed forces, was referred by the House to the Board of Trustees for study and action.

A resolution introduced by the Iowa State Medical Society, calling for approval of a joint-billing procedure involving services rendered by two or more physicians, was referred to the Judicial Council, at the suggestion of the Reference Committee on Miscellaneous Business, with the recommendation "that the Judicial Council investigate the factors involved in the matter as presented and determine if there are new factors or new facets that would cause it to change the opinion" determined in 1952.

The House approved a revision of one section of the Principles of Medical Ethics of the A.M.A. which clarifies the relationship of physicians to all forms of public information media. The revision had been worked out by the Council on Constitution and Bylaws.

In an effort to solve the publicity problems resulting from unethical practices by a small minority of doctors, the House referred to the Board of Trustees a resolution calling for appointment of a special committee with broad professional representation to study all aspects of the problems. The Board was asked to study and implement the intent of the resolution and to report its findings to the House at the June, 1954, meeting in San Francisco.

### Seek Accreditation Explanation

To clarify misunderstandings among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of the Department of General Practice in a hospital, the House adopted the following resolution:

"That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in the Journal of the American Medical Association and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, bylaws and their interpretations, and

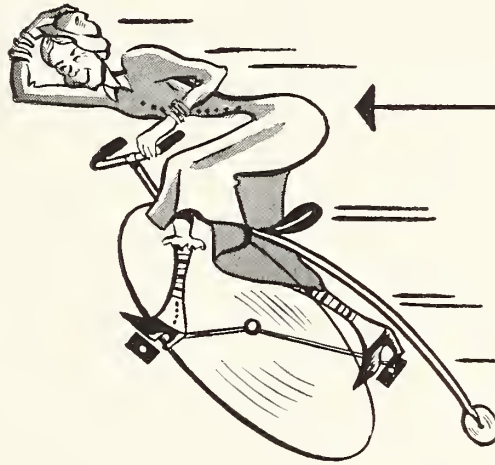
"That the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

In the field of medical education the House was "pleased to note" that a fourth grant of \$500,000 had been made by the American Medical Association to the American Medical Education Foundation for financial aid to the nation's medical schools. The Foundation reported that its 1953 income now totals \$1,174,000 and that the number of contributors now is more than double the total in 1952.

Dr. Louis H. Bauer, of New York, immediate past president of the A.M.A., was elected president of the Foundation just prior to the opening of the A.M.A. Clinical Session. He succeeds the late Dr. Elmer L. Henderson of Louisville, also an A.M.A. past president.

At the opening session of the House, Dr. McCormick in his presidential address made a strong appeal to the nation's physicians for "action that will further the full confidence of the public in our profession."

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"Good public opinion cannot be bought," he declared. "It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the A.M.A. and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures."

Dr. Reuling, emphasizing that much serious work remains to be done, warned that "times are just as troubled as when we had blanket bills before Congress which would have socialized the practice of medicine."

Dr. Keefer told the House that "the voluntary way has been the most successful in the past and there is no reason to believe it will not continue to be in the future." He urged maximum effort, cooperation and leadership on the community level.

Just prior to the Clinical Meeting the Joseph Goldberger award for outstanding contributions in the field of clinical nutrition was presented to Dr. James Somerville McLester of Birmingham, Alabama, a practicing physician for more than 50 years. The award was presented by the A.M.A. through its Council on Foods and Nutrition.

Final registration at the St. Louis Clinical Session was expected to total approximately 7,500, including about 2,700 physicians.

Indiana delegates seated at the Clinical Session were Karl R. Ruddell, M.D., Indianapolis; Wendell C. Stover, M.D., Boonville; Cleon A.

Nafe, M.D., Indianapolis; and Eli S. Jones, M.D., Hammond.

Indiana doctors who registered during the session included James M. Brown, Anderson; Patrick J. V. Corcoran, Evansville; Frank P. Albertson, Indianapolis; Joseph Emory Ball, Indianapolis; Lester David Bibler, Indianapolis; Theodore J. Bruegge, Kokomo; Eldo H. M. Clauser, Muncie; Harry E. Danielson, Jr., Plymouth; Wm. D. Dannacher, Wabash; Otto R. Dobbs, Greencastle; George M. Ellis, Jr., Connersville; Paul W. Ferry, Kokomo; Orville M. Graves, Sr., Princeton; Frank H. Green, Jr., Rushville; Milton Herzberg, Clinton; Don G. Hilddrup, Indianapolis; Ammon W. Hoover, Michigan City; John Horace Houseworth, Bloomington; Seth H. Irwin, Summitville; Francis P. Jones, Indianapolis; Horace E. Jones, Anderson; Maurice V. Kahler, Indianapolis; Harry E. Klepinger, Lafayette; Jerome M. Korn, Gary; Hugh E. Martin, Indianapolis; Justin R. Nash, Albion; Leonard G. Paul, Michigan City; Kermit F. Perrin, Fort Wayne; Harold G. Petitjean, Haubstadt; Wayne G. Pippenger, Brook; Rex K. Pomeroy, Plymouth; Francis M. Sellers, South Bend; John M. Sullivan, Terre Haute; Clayton G. Weigand, Indianapolis; Robert H. Williams, Anderson; Jos. Wm. Wright, Indianapolis.

Among lay executives registered were James A. Waggener, executive secretary of Indiana State Medical Association and Robert J. Amick and Kenneth W. Bush, field secretaries.

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With this issue THE JOURNAL inaugurates a new feature—a summary of Washington news—which will be airmailed from the capital on the ninth of each month.\*

## THE MONTH IN WASHINGTON

Washington, D.C.—The second session of the 83rd Congress is getting down to its task under conditions that could mean passage of considerable legislation of importance to medicine. Holding over from last session, or certain to be introduced this year, are bills touching on virtually every phase of medicine where the federal government could become involved. New laws are being proposed on veterans' care, social security, national health plans, care of military dependents, medical scholarships for military personnel, and many other subjects.

What will be done with this mass of legislation depends on an administration whose control over Congress is tenuous and a Congress looking forward to the fall, when all members of the House and one third of the Senate must be elected or reelected. As is the case every two years, most lawmakers will be listening closely to what's being said back home.

Awaiting congressional action is the administration's plan for extending the social security system to bring more than 10,000,000 additional persons, including physicians, under Old Age and Survivors Insurance (OASI). This legislation is known to have less support in the House Ways and Means Committee, where it is being handled, than it has in the Executive Branch.

American Medical Association, supported by dentists, lawyers, farmers, and many other groups of self-employed, has consistently opposed inclusion under OASI. The question now is whether this opposition will be articulate enough to convince Congress.

In place of social security for physicians, the

AMA for several years has actively promoted legislation identified first as Reed-Keogh, then Jenkins-Keogh, named for the sponsoring congressmen. This would allow physicians and other self-employed to defer income tax payments on a portion of their income, placed in restricted pension funds, obtainable in the form of benefits only in case of disability or at the specified retirement age. In this effort the physicians again are joined by a large group of associations representing the self-employed.

Other possible amendments to the social security law involve total and permanent disability payments and waiver of OASI premiums for the disabled, so their final pensions won't be reduced because of periods when they had little or no income. In each of these, medical determinations would be required. In the past, these bills have threatened an expansion of the federal medical program, have laid out an unreasonable role for the physician, or have called for compulsory rehabilitation. While not opposed to the objectives, AMA has urged that both the patient and the physician be protected. In place of waiver of premium, the AMA proposes that pension rates be based on the 10 best earning years, thus obviating the need for medical determinations.

As in other sessions, Congress this year probably will be asked to pass legislation providing free hospitalization under OASI for all persons past 65 covered by OASI, and for other beneficiaries of the program. In other years Congress has not taken this idea seriously.

### —On Veterans Problems

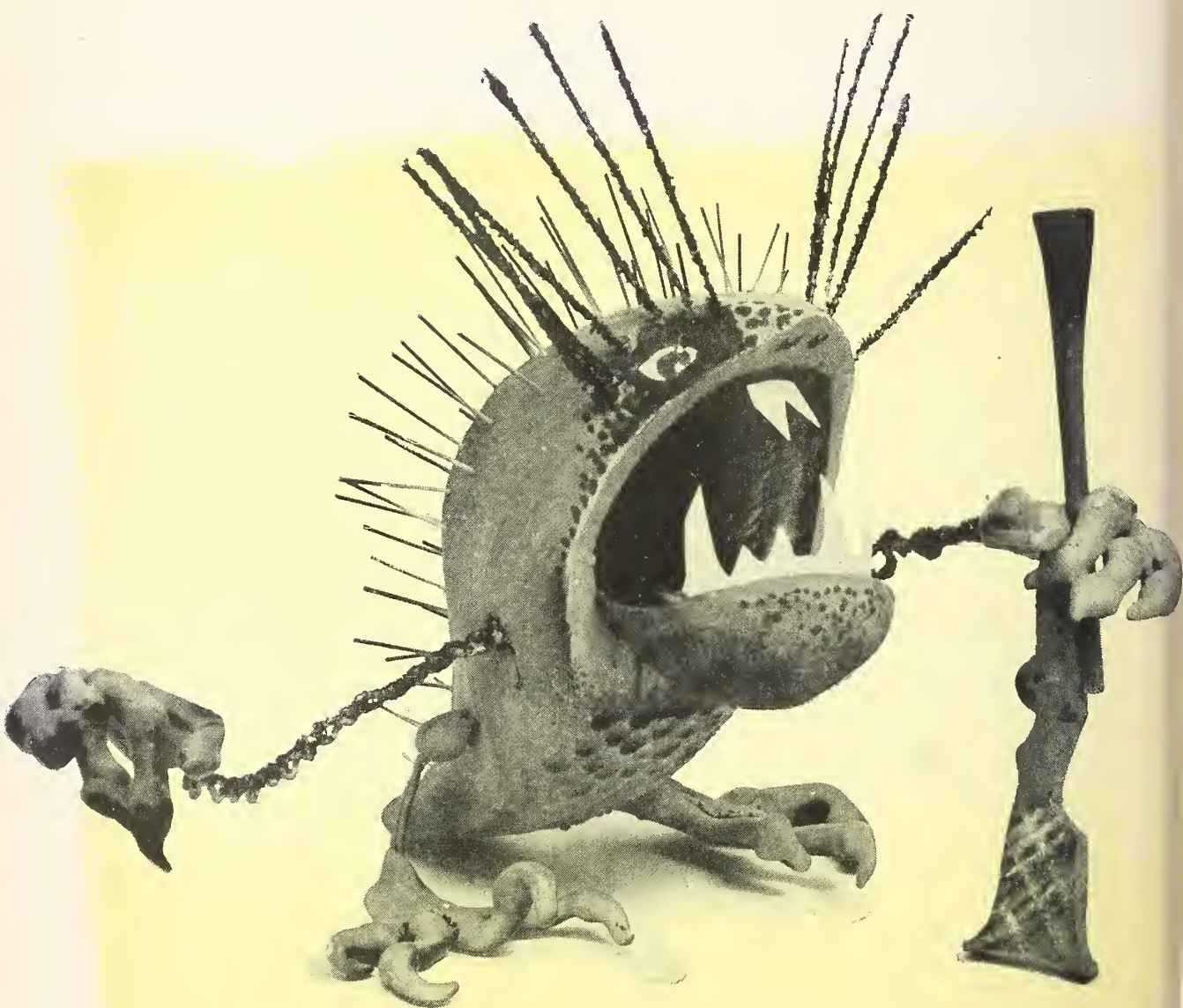
The veterans program is certain to provoke action. Last November, Veterans Administration amended its forms to require more financial

\* This is a service from the Washington office of the American Medical Association.



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information from veterans applying for hospitalization of non-service connected disabilities, who must state that they cannot afford private care. Congress may want to further clarify the government's obligation to veterans. It is expected also that special effort will be made to expand medical benefits for veterans by such methods as increasing the periods in which certain diseases may be presumed to be of service origin.

AMA's position on the care of non-service connected cases is well known. It consists of three points. First, the best possible care by VA for actual service-connected cases. Second—until local and state facilities are adequate—VA care for long-term tuberculosis and neurological cases when the veteran himself can't pay. Third, all other non-service connected cases to be the responsibility of the veteran himself, his family, or his community.

The Defense Department has served notice that this session it will press hard for implementation of the Moulton Commission's recommendations for broadening the medical care program for military dependents. The Commission fa-

vored caring for as many dependents as possible at military installations, with the others receiving private care and the federal government paying all but a token of the cost. At its December meeting, the AMA's House of Delegates proposed that in this country the military provide medical care for dependents only where private facilities are not adequate.

Also up for decision this year is a Defense Department's proposal that the federal government furnish medical, dental and nursing scholarships, with the recipients obligated for government service at the rate of one year for every year of the scholarship.

### —And Health Insurance

There is a strong possibility of pressure to enact a program under which the federal government would in one way or another subsidize private health insurance plans. The idea is known to interest Rep. Charles Wolverton (R., N.J.), chairman of the House Interstate and Foreign Commerce Committee, which last fall conducted a series of hearings on health matters. Senators Ives (R., N.Y.) and Flanders (R., Vt.) are offering a bill along the same lines in the Senate.

The controversial Bricker resolution holds over from the last session, and may receive early consideration in the Senate. Senator Bricker believes that Congress should have some check on the President's treaty-making powers. The American Medical Association repeatedly has indorsed the Bricker resolution as a safeguard against the introduction into this country by treaty of government-controlled medical plans without Congress itself having a chance to pass on them.

Awaited with interest in Washington are the findings of two Commissions appointed last year to look into the relationships between the federal government on the one hand and state and local governments on the other, and to investigate operations of the executive branch. The former is headed by Clarence Manion and the latter by former President Hoover. The Hoover Commission has until next year to make its report. The Manion Commission was instructed to have a report ready by March, but it may ask for more time.



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# Deaths . . .

**Jewett V. Reed, M.D.**, pioneer Indiana brain surgeon, died in his Indianapolis home December 4. He was 75 years old.

Doctor Reed was among the first doctors to diagnose and treat brain tumor surgically and also pioneered in the establishment of the Indianapolis Industrial Clinic, first clinical service provided to handle industrial medical and surgical problems.

Born in Jeffersonville in 1878, Doctor Reed received his degree in medicine and completed his internship at Johns Hopkins University School of Medicine in 1904. He had practiced in Indianapolis for 45 years. During World War I he served as a surgeon in a U. S. Naval Hospital at Portsmouth, New Hampshire. For the last 10 years Doctor Reed had devoted most of his time to the management of the clinic which he and E. Bishop Mumford, M.D., had founded in 1920.

For many years Doctor Reed was active in affairs of the Indiana State Medical Association. He served from 1907 through 1911 on the Committee on Pathology, later was a member of the Committee on Medical Research and Postgraduate Work and on Scientific Demonstrations. In 1927 he was chairman of the Committee on Scientific Work, following which he served on the Committees on Civic and Industrial Relations and Insurance. He was assistant professor emeritus of surgery at Indiana University School of Medicine, a fellow of the American College of Surgeons, and member of the American and Indiana State Medical Associations.

**Robert A. Smith, M.D.**, 51, New Castle ophthalmologist and otolaryngologist, died suddenly December 7. He had not been ill previously. Doctor Smith was a member of a family of physicians. His grandfather, grandmother and father were all practicing physicians in Henry county.

Doctor Smith was a 1926 graduate of the Indiana University School of Medicine, interned at Methodist Hospital, Indianapolis, and had practiced in New Castle since. During World

War II Doctor Smith served in the Army Medical Corps. He was chief of the eye, ear, nose and throat section at Fitzsimmons General Hospital, Denver. In this post he gained recognition for plastic surgery performed on injured veterans. He held the rank of colonel.

Doctor Smith served the Henry County Medical Society as secretary for 17 years, from 1930 to 1947. He became vice-chairman of the Indiana State Medical Association Section on Ophthalmology in 1947 and became section chairman in 1951 and 1952. He had also served on the Committees on Conservation of Vision and on Hard of Hearing.

He was certified by the American Board of Otolaryngologists, was a member of the American Academy of Ophthalmology and Otolaryngology and other special societies and of the American Medical Association.

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**Jones Lindley Saunders, M.D.**, 72, Newport physician for 37 years, died November 12 in the Vermillion County Hospital following a heart attack suffered two days earlier. Doctor Saunders was a native of Tennessee. He received his medical degree from Rush Medical College in Chicago in 1904 and began the practice of medicine in Georgetown, Illinois. He went to Newport in 1916, left to serve as a major during World War I, and returned after the war to continue his general practice. He was a member of Parke-Vermillion County Medical Society, the Indiana State and American Medical Associations.

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**John A. Kent, M.D.**, 80, Mulberry, died December 1 in a Rochester, Minnesota hospital.

Doctor Kent was born in Clinton County. He received his medical degree from Illinois Medical College at Chicago in 1902. He also studied at Johns Hopkins University, Baltimore. After practicing in Scircleville for three years, Doctor Kent went to Mulberry where he practiced for 47 years. He was a senior member of the Clinton County Medical Society and the Indiana State



Medical Association and a member of American Medical Association.

Arthur G. Funkhouser, M.D., 59. Indianapolis physician for 30 years, died November 21 in the Veterans Administration Hospital. He had been ill for several months.

A native of Indianapolis, Doctor Funkhouser was graduated from the Indiana University School of Medicine in 1923. He completed his medical education after returning from service during World War I. He was a chief pharmacist with the U. S. Navy serving in the United States and at Inverness, Scotland.

Throughout his career, Doctor Funkhouser was associated with his cousin, Dr. Elmer Funkhouser. He served on staffs at Methodist and St. Vincent's Hospitals, Indianapolis and was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.

Frederick S. Cuthbert, M.D., 77, retired physician, died in his sleep at his Kokomo home

November 20. Although he had retired in 1949 when he became ill from a heart disorder he had been in his usual health immediately prior to his death.

Born in Hollandsburg, Doctor Cuthbert taught school for eight years after completing his early education, then went to the University of Illinois College of Medicine where he received his medical degree in 1905. He began the practice of medicine at Kingman where he remained for 14 years before going to New York City to study as a specialist in ophtalmology and otolaryngology. He completed his work at New York Postgraduate Hospital in 1920 and went to Kokomo that year where he had practiced his specialty since.

Since his retirement Doctor Cuthbert had devoted more time to his farms and had learned to paint in oils. Two of his pictures have been hung in Kokomo public buildings.

Doctor Cuthbert was a member of Howard County Medical Society, the Indiana State and American Medical Associations and of the Indiana Society of Ophthalmologists.

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# NEWS NOTES — from State and Nation

## Dr. White Named to I. U. School of Medicine Faculty

Dr. Philip Taylor White, native of Anderson, has been appointed assistant professor of neurology at the Indiana University School of Medicine, by the board of trustees of the university.

Doctor White received his medical degree from George Washington University School of Medicine and studied for his M.S. in neurology at the Mayo Foundation of the University of Minnesota. He served residencies in psychology in 1949-50, residencies in neurology in 1950-51 at Indianapolis General Hospital, and as a fellow and first assistant in neurology at the Mayo Clinic, Rochester, Minnesota.

**Drs. M. S. Brown and D. S. Blackwell** have closed their office in Ellettsville to devote full time to their practice in Spencer.

**Dr. W. W. Stogsdill** has opened the former offices of Dr. R. C. Wilson at 172-176 East Jefferson Street in Franklin where he will be in the general practice of medicine. He was recently discharged from service. Doctor Stogsdill is a graduate of Indiana University School of Medicine, served his internship at the U. S. Naval Hospital, San Diego, California, and his residency in general practice at Ball Memorial Hospital, Muncie. He is married and has three children.

**Dr. Ralph O. Bosch**, a native of Cincinnati and 1945 graduate of the University of Cincinnati College of Medicine, plans to establish an office for the general practice of medicine in Seymour where he is now living. He served his internship at Christ Hospital, Cincinnati, and took postgraduate training with the Veterans' Administration at Louisville. Before going to

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Seymour Doctor Bosch was on contract work with the VA in Muskogee, Oklahoma. Mrs. Bosch is a registered nurse.

**Dr. Richard J. McIlroy**, who formerly practiced at Claypool and Milford for two years and has recently served two years with the Army Medical Corps in France, has joined the staff at Richmond State Hospital. Doctor McIlroy received his medical degree from Queen's University, Kingston, Ontario, served his internship at White Plains, New York, hospital and residency in the Dade County, Florida, hospital.

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with state chapters and the staffs and faculties of local hospitals and medical schools, will sponsor the second regional post-

graduate course on diseases of the chest in New Orleans, February 15-19. A similar course will be held in Philadelphia, March 15-19. Tuition for each course is \$75.

Full information may be secured by writing the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

An office for the general practice of medicine has been opened at 7017 Pendleton Pike by **Dr. Frederic A. Rice, Jr.**, a veteran of six years service with the army. Doctor Rice is a graduate of Indiana University School of Medicine, 1951, and served an internship at Percy Jones Army Hospital, Battle Creek. Since returning from service he has been with the medical department at the Allison Division of General Motors, Indianapolis.

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### International Group of Doctors in AA to Meet

The Fifth Annual meeting of an International Group of Doctors in Alcoholics Anonymous will be held in the Mayflower Hotel, Akron, Ohio, May 14, 15 and 16, 1954. For full information and reservations address: Doctors, Mayflower Hotel, Akron, Ohio.

The group was formed five years ago by a few doctors from New York. The last meeting was attended by men from widely separated localities.

Both Indiana and Purdue Universities have received contract renewals from the United States Atomic Energy Commission for research projects in fields related to atomic energy. The award to the Indiana University Foundation is for research on "The Influence of Radiation in Altering the Incidence of Mutations in *Drosophila*" with Dr. H. J. Muller acting as investigator. At Purdue work is being continued on "The Physiology of Hydrogen Bacteria" with Henry Koffler and D. M. Powelson in charge.

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## American Foundation for Allergic Diseases Formed

Under the joint sponsorship of the American Academy of Allergy and the American College of Allergists, a new national, non-profit organization has been formed. It has been incorporated under the laws of New York state as The American Foundation for Allergic Diseases. Its program has been outlined as one of education, information, cooperation with established institutions for the treatment and prevention of allergic diseases, and research.

Officers of the new group are Dr. Horace S. Baldwin, New York, president; Dr. J. Warrick Thomas, Richmond, Virginia, vice-president; Dr. Bret Ratner, New York, secretary; and Dr. Theodore L. Squier, Milwaukee, treasurer.

Dr. Emor L. Cartwright, Fort Wayne, is serving as president of the six-state Ohio Valley Proctologic Society and presided at the group's first fall meeting held in Cincinnati. The Fort Wayne surgeon is one of the founders of the society which has members from Indiana, Ohio, Illinois, Kentucky, West Virginia and Pennsylvania.

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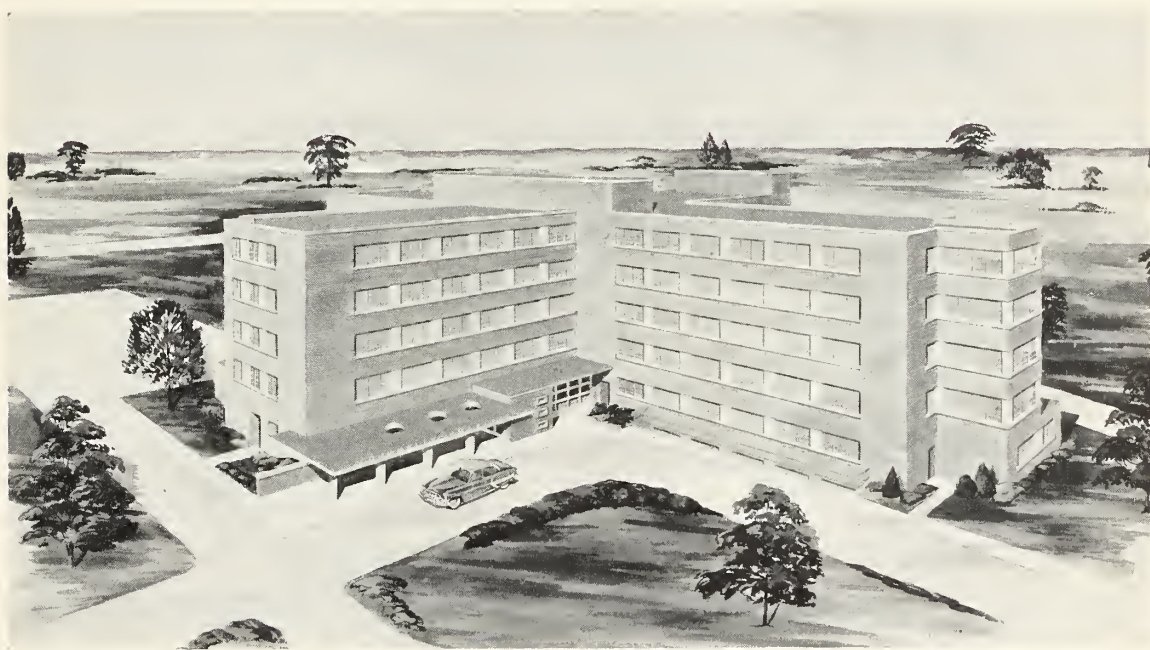
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## COMMUNITY HOSPITAL CONSTRUCTION TO START IN SPRING: INDIANAPOLIS' OWN PROJECT



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Work will begin during the early spring on the 5-story structure at 16th and Ritter streets. Approximately \$5,000,000 has been set aside for construction and maintaining the hospital until its revenue meets operating costs.

The hospital, as shown in the architect's drawing above, is to be on street level and will incorporate many new and time-saving features.

The Community Hospital, built by private donations, will be operated as a non-profit community undertaking. A corporation will be formed by members who will pay a small annual fee and who will elect a Board of Trustees, to serve without pay.

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Classes will meet from 7 to 9 each Wednesday evening with Dr. Louis N. Katz, director of the cardiovascular department, in charge.

Copies of the lecture schedule and applications

may be secured from Mrs. Rivian H. Lewin, Administrative Secretary, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

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**Dr. William D. Ritchie**, a native of Evansville, has opened offices for the general practice of medicine and surgery at 2010 Stringtown Road in that city. Doctor Ritchie, a 1948 graduate of Indiana University School of Medicine, has recently been separated from active duty with the U. S. Air Force. While in service he attended the Air Force School of Aviation Medicine and served as flight surgeon for Randolph Air Force Base in Texas. Doctor Ritchie served his internship at Ball Memorial Hospital, Muncie, and prior to entering service was associated with Dr. W. Lawrence Daves in the general practice of medicine.

**Dr. T. D. Rhodes** is spending six months in Florida after which time he will resume his practice in Indianapolis. His address is Box 76, Punta Gorda, Florida.

**Dr. Victor C. Moeller** has returned to his native city, Fort Wayne, to open an office at 4349 South Anthony Boulevard for the general practice of medicine and surgery. He completed his internship in July at Indianapolis General Hospital. Doctor Moeller is a 1952 graduate of I. U. School of Medicine. He served as a navigator in the Air Force during World War II.

**Dr. Jack Porter**, who has just been released from active duty with the U. S. Air Force, has reopened his office at 209 West North Street in Lebanon. He established his office there in 1948. He entered service in 1950 and since has served in Texas and with the Third Hospital group in England where he was chief of the department of internal medicine at Wimpole Park. Doctor Porter is an I. U. graduate.

# Books: Received and Reviewed

**PRACTICE OF PSYCHIATRY.** By William Sadler, M.D., F.A.P.A., Consulting Psychiatrist to Columbus Hospital and Pinel Sanitarium, Chicago. Cloth. \$15. Pages, 1183. C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo., 1953.

Doctor Sadler, a pioneer in the field of psychiatry, has made many contributions to the literature. His volume, **MODERN PSYCHIATRY**, was published in 1945. The author felt that it would be best to rewrite the book rather than revise it due to the marked progress that has been made in the field of psychiatry since that time.

The book consists of 75 chapters with an appendix of 40 pages discussing the various schools of psychiatry. In addition to the above, an extensive bibliography and glossary are included; all in all, a total of 1183 closely typed pages. Doctor Sadler has attempted to cover the entire field of psychiatry, paying homage to the many individuals who have made contributions in the field of psychiatry. In doing this, he has tended to give long descriptions of the psychopathology found in mental illness, neglecting reasonable explanations regarding the causation of these diseases. As a result, he has compiled a tremendous amount of data which is of historical interest to the psychiatrist. The book, in reality, is divided into seven parts, i.e., "General Psychiatric Considerations," "The Pathoses," "The Neuroses," "The Psychoses," "Personality Disorders," "Psychosomatic Disorders," and "General Psychotherapeutics."

The chapter on psychiatric tests is well written, the author discussing in detail the various tests that he has found to be most helpful in the private practice of psychiatry. General psychotherapeutics are discussed in 17 chapters. The titles of some of these are: "Suggestion and Hypnosis," "Re-education and Remotivation," "Therapeutic Study Program," "Sublimation and Fear Management," "Habit and Self-Control," and "Philosophy and Religion." The chapters on therapy are most interesting, but it would be rather difficult for the practitioner to arrive at any useful therapy from the descriptions as given. In his chapter on management of nervous and mental disease, the author describes several types of treatment that are little known in the field of psychiatry, such as the cold mitten friction treatment, deep massage of the abdomen with a small cannon ball, and electricity administered by the method known as autocondensation. The use of these treatments in the modern therapeutic regime certainly is debatable. The chapter on shock treatment is well written, the various therapies being discussed in a detailed manner.

Doctor Sadler brings us many worthwhile bits of personal philosophy and detailed techniques of therapy that he has used in his practice over the many years. The author has produced a book which contains a tremendous collection of psychiatric material which will be of interest to all specialized workers in the field of psychiatry.

M.F.G.

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# Society Reports

## EXECUTIVE COMMITTEE

November 15, 1953

Roll call showed the following present: James W. Denny, M.D., chairman; E. P. Clauser, M.D.; Wm. Harry Howard, M. D.; W. L. Portteus, MD.; Roy V. Myers, M.D.

Albert Stump and Robert Hollowell, attorneys; J. A. Waggener, executive secretary; R. J. Amick and K. W. Bush, field secretaries.

### Membership Report

Number of members November 14, 1953. 3,801\*  
 Number of members November 14, 1952. 3,750  
 Gain over last year ..... 51  
 Number of members December 31, 1952. 3,787

\* Includes 143 in military service (gratis)  
 116 \$10.00 members (residents and interns)  
 251 senior members  
 75 members, dues remitted by Council

Number who have paid AMA dues:

1951...2,997; 1952...3,569; 1953...3,598\*\*

\*\* 420 members who were permanently exempted in 1952 are included in above figure.

### Headquarters Office

Mr. Amick, field secretary, reported the interest of several southern counties in forming joint societies and he is to recommend to the interested counties that they contact their councilor regarding this matter prior to the January meeting of the Council.

He also reported the enthusiasm of the members of the Vanderburgh County Medical Society over the series of health forums currently being conducted, also reporting that the Owen-Monroe County Medical Society was conducting a survey at their own expense to determine the necessity of expanding local hospital facilities.

Mr. Bush reported that he had been assisting in the office and had not been in the field too long but had visited seven counties.

*Storage cabinet.* Upon motion of Drs. Howard and Portteus the secretary was authorized to purchase an additional storage cabinet for the headquarters office.

### Treasurer's Office

On motion of Drs. Myers and Portteus the George S. Olive & Company is to be employed to make the annual audit of the books.

Statements of receipts and expenditures and report on the budget for October for the Association and THE JOURNAL were approved.

## Legislative Matters

### National:

The secretary reported on the hearings being held by the House Interstate Committee on the Health Problems of the Nation, especially the payment for medical care by the so-called middle income groups in case of chronic illness.

The secretary also reported that Mrs. Hobby, director of the Department of Health, Education and Welfare, in all of her major addresses has made the statement that the extension of the social security system will be the priority matter to come before the Congress in January. This extension of social security is an administration campaign promise and proposes to include all professional people and self-employed under the social security plan. This matter was discussed thoroughly by the committee and the secretary was instructed to write all Congressmen opposing inclusion of the medical profession in this plan. Also, the component county medical societies are to be urged to contact or write their Congressmen on this matter.

The field secretaries were instructed to contact as many counties as possible to discuss this matter and also to contact the Congressmen who were at home and to attempt to assist county medical societies in arranging a contact with these Congressmen.

The secretary was also instructed to prepare a special bulletin for mailing to all component county societies on this matter.

### 1953 Annual Convention, French Lick, October 19, 20 and 21, 1953

The final report on the income from sale of exhibit space and the financial report on instructional courses were reviewed by the committee as well as letters from some of the exhibitors and personal opinions of members of the committee.

### 1954 Annual Convention, Murat Temple, Indianapolis, October 25, 26 and 27, 1954

*Speakers' honorariums.* On motion of Drs. Myers and Howard outstate speakers are to be paid an honorarium of \$100.00.

The Executive Committee is to suggest to the Committee on Scientific Work that not more than fifteen out-of-state speakers be invited to participate in the 1954 convention.

*Meeting dates.* Upon motion of Dr. Portteus the Executive Committee is to recommend to the Council that the dates of the 1954 meeting be changed so as to hold the regular convention on Monday, Tuesday and Wednesday, October 25, 26 and 27, with the



Executive Committee, Council and House of Delegates meeting on Sunday, October 24. This was adopted by consent.

*Exhibit rules.* By consent it was agreed that the exhibit rules for the 1954 meeting should be the same as they were for the 1953 meeting.

The secretary discussed some of the problems of selling exhibit space and reviewed some of the plans of other states in which exhibitors at the immediate convention just closed are given preference in reserving space before making a blanket mailing to other exhibitors. The committee felt that this would be advisable to try in 1954.

Permission was granted the secretary to accept exhibits from the tobacco companies in 1954.

The secretary was also given permission to work out another promotional scheme for encouraging exhibit visitation in 1954.

*Exhibit hall entrance.* The secretary spoke of the method being used in some states for a formal entrance to the exhibit hall, Dr. Howard telling about the method used at the Michigan meeting, and by consent it was agreed that the secretary should attempt to work out a similar plan for Indiana.

*Scientific exhibits.* A letter from Dr. J. L. Arbogast, chairman of the Committee on Scientific Exhibits, was read to the committee, and the secretary is to check with other states in regard to their manner of holding scientific exhibits and report back at the next meeting of the committee.

#### Organization Matters

The action of the House of Delegates instructing that a resolution be presented at the A. M. A. interim session in St. Louis on December 1 relative to the Joint Commission on Accreditation of Hospitals was discussed. By consent it was agreed that Drs. Denny, Myers, Portteus and Nafe were to attempt to formulate a resolution in accordance with the instructions of the House and to have same ready for discussion at the special dinner meeting of the Indiana delegation and officers who might be attending the A. M. A. meeting, and the secretary was instructed to arrange such a dinner meeting at the Jefferson Hotel, Monday night, November 30.

*Membership in Indiana State Chamber of Commerce.* Upon motion of Drs. Portteus and Myers dues to the Indiana State Chamber of Commerce in the amount of \$100.00 were approved for payment.

*National Society for Medical Research.* Upon

motion of Dr. Howard, a contribution to the National Society for Medical Research in the amount of \$100.00 was approved by consent.

Letter from the investment firm of Merrill Lynch, Pierce, Fenner & Beane was read, in which a film on investments was offered for distribution to the membership of the county societies, but no action was taken.

By consent the secretary was instructed to reprint sufficient copies of the Constitution and By-laws for distribution to the component county medical societies and others.

Mr. Stump gave a report on the booklet he is preparing on malpractice, and he and Mr. Hollowell were instructed to review this question and to bring it up at the next meeting of the committee.

#### The Journal

*Report on advertising* for October and report on the first three quarters of the year, as well as the anticipated advertising income for the last quarter, was given.

A letter from Dr. Denny to the editor of THE JOURNAL was read in which he recommended that a page be set aside each month for use by the Woman's Auxiliary which would carry a message from the Auxiliary president as well as a report on the programs or activities of the Auxiliary. Upon motion of Dr. Portteus the Executive Committee is to recommend that THE JOURNAL try this system, and approval was given by consent.

#### New Business

(1) The secretary called to the attention of the committee a statement made by the president that the association should cooperate with the Blue Shield Plan in conducting meetings for doctors' office secretaries and assistants. He requested to know if that was to be the policy of the association and if it was the intent that we should actively participate in the program of these meetings, and upon motion of Drs. Howard and Clauser it was agreed that the association should participate in conducting these programs by presenting material relative to medical public relations.

#### Future Meetings

Permission was granted for both field secretaries to attend the Public Relations and Clinical Sessions of the A. M. A. at St. Louis, November 30 to December 4, 1953.

By consent it was agreed that the next meeting of the Executive Committee would be held at 11:00 a. m., Sunday, December 13, 1953, in the Conference Room at the Indiana University Medical Service Center.

There being no further business, the meeting adjourned.

# News from the County Societies

Roy J. Gibbons, science editor of the Chicago Tribune, was the guest speaker at a press-radio-medical dinner meeting sponsored by the **Fort Wayne (Allen County) Medical Society** December 1. Seventy-two physicians and 22 guests from newspapers and radio stations attended the dinner in the Chamber of Commerce and heard Mr. Gibbons discuss "The Need for Cooperation Between Medicine and the Press and Radio." Mr. Gibbons is the only newspaperman to be made a citizen-fellow of the Chicago Institute of Medicine. With a record 30 years of science reporting as background, he was speaking with authority when he told his Fort Wayne audience of the great need for improved public relations in medical groups.

The November scientific program of the Fort Wayne society was presented by the medical staff of Lutheran Hospital at a dinner meeting in the

Chamber of Commerce. "A Symposium on Trauma" was presented by Dr. W. D. Griest, chairman, Dr. F. W. Brown, Dr. F. A. Bryan, and Dr. C. G. McEachern. Topics discussed by the panel were orthopedic trauma, thoracic and abdominal injuries and plasma expanders. A round table discussion followed.

The January meeting was scheduled for January 5 in the Chamber of Commerce when the Indiana Academy of General Practice will present one of their "Road Shows".

Election of officers for 1954 and organization of the staff for Clay County Hospital, highlighted the **Clay County Medical Society's** business meeting held following dinner December 8 in the Brazil Elks' Club. Eight members attended. Date for the next meeting is January 19 in the Brazil Elks' Club.



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Twelve members of **Dubois County Medical Society** met in the Jasper Legion Home December 10 at 6 p.m. for a joint dinner meeting with the auxiliary. Doctors went into a business session following the dinner to elect officers for 1954. The next meeting will be held in Huntingburg at 6 o'clock February 11.

Dr. Max M. Montgomery, associate professor of medicine at the University of Illinois, Chicago, was the guest speaker at the December 3 meeting of **Elkhart County Medical Society**. Seventy members were present at the dinner in the Hotel Elkhart to hear Doctor Montgomery discuss "Arthritis".

At the business meeting following the dinner officers for the coming year were elected; the group voted unanimously to oppose extension of Social Security to include doctors but approved the Jenkins-Keogh bill or a similar measure. Members were urged to contact their congressmen and senators.

The next meeting was set for January 7 in Hotel Elkhart.

Officers for 1954 to serve the **Fayette-Franklin County Medical Society** were elected at a dinner meeting December 8 in the Connersville Country Club. Thirteen doctors attended the meeting.

Dr. Frank Adney, Richmond, will be guest speaker at the January 12 meeting in the Connersville Country Club.

On November 10 Dr. Robert Johnston, Cincinnati, spoke to 17 members of the society on "Toxemia of Pregnancy" which he illustrated with a film. Later the film "Without Fear" was shown and a report given on the action of the

House of Delegates of Indiana State Medical Association by Dr. J. M. Lockhart.

"Psychiatry in General Practice" was the title of the paper presented by Dr. Jarrett Ringham, Evansville, to members of the **Gibson County Medical Society** at their November 19 meeting. A lengthy discussion by the 18 members present followed. The meeting was held in the Emerson Hotel, Princeton.

**Hendricks County Medical Society** members met at noon December 8 in Danville for a luncheon meeting at which Dr. Glenn Irwin, Indianapolis, spoke on "Thyroid Disease and Newer Therapy". The seven members present also elected 1954 officers.

The Medical society and auxiliary held a joint luncheon meeting in October at the O.K. City restaurant in Danville. Dr. DeWitt W. Brown, Indianapolis, was the guest speaker. His paper was on "Present Treatment of Fat Embolism."

The annual election meeting of the **Howard County Medical Society** was held November 3 in the Hotel Frances, Kokomo. In addition to the county officers several committee chairmen were named and Dr. Warren McClure was voted to membership in the society.

The **Jasper-Newton County Medical Society** met December 9 in the Brook Hotel in Brook for a dinner meeting, special program and election of officers. Drs. Albert L. Marshall, Jr. and Samuel R. Damon, Indianapolis, discussed "State Board of Health Functions". The 18 members present elected officers and

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announced the next meeting date would be January 13 in the Brook Hotel.

All Kosciusko County Medical Society members attended the first fall meeting of the society on October 20 in North Webster. Members of the auxiliary joined the doctors for dinner in the M & M Cafe in North Webster where Dr. and Mrs. J. W. Stalter were hosts.

Separate meetings of the two groups were then held in the Stalter home.

Warsaw city police and the Kosciusko County sheriff's office provided emergency telephone and radio service which permitted all doctors to attend the meeting.

Guests from the Blue Cross and Blue Shield headquarters joined Lawrence County Medical Society members in a meeting November 4 in Dunn Memorial Hospital, Bedford. Twenty-two attended the luncheon and heard discussions of problems common to the two groups.

Dr. John A. Shively of the Caylor-Nickel Clinic, Bluffton, was the guest speaker at the November 19 meeting of Montgomery County Medical Society in Culver Hospital, Crawfordsville. He spoke on "Fluid Balance and the Electrolytes in the Body" following a dinner in the hospital dining room.

At the October meeting of the society, also held in Culver Hospital, Dr. Robert J. Rohn, Indianapolis, assistant professor of medicine at Indiana University School of Medicine, spoke

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on "Hematology". He illustrated his talk with interesting special process color films taken at the Medical Center.

---

Officers were elected by the **Orange County Medical Society** at a December 1 dinner meeting in the West Baden Springs Hotel. Eight members attended the dinner and business meeting. The next meeting will be held January 5 in the French Lick Springs Hotel.

A general discussion followed the meeting of the society November 3 in Wagner's restaurant in Paoli.

---

Dr. Joseph E. Tether, Jr., Indiana University Medical Center, Indianapolis, presented a paper on "Myasthenia Gravis" to members of the **Owen-Monroe County Medical Society** on November 19. Thirty members attended the dinner meeting in the Bloomington Country Club. Doctor Tether illustrated his lecture with a film showing patients before and after treatment.

---

Members of the **Parke-Vermillion County Medical Society** held a dinner meeting in the Vermillion County Hospital November 18 with 14 members in attendance. Following the dinner Robert J. Amick, I.S.M.A. field representative for southern Indiana, reported on action taken by the House of Delegates at the annual convention and discussed a number of matters of interest to the county society.

Announcement was also made that the Parke-Vermillion County Medical Society has established an emergency call service at the Vermillion County Hospital to provide round-the-clock medical care to all persons in the area.

---

"Orthopedics the Man in General Practice Should Do" was the subject of a paper presented by Dr. Gordon Batman, Indianapolis, to 14 members of the **Putnam County Medical Society** on December 11. Doctor Batman spoke following a dinner in the DePauw Union building. Officers were elected in a business meeting held following the program.

At the November 13 meeting of the society in the Union Building, Dr. L. A. Malone, Terre

Haute, was the guest speaker. He discussed "Irradiation Therapy". R. J. Amick, I.S.M.A. field secretary, gave a general report including action taken by the House of Delegates at the French Lick convention. Fourteen members were present.

---

Members of the **Shelby County Medical Society** met informally with the Hon. Ralph Harvey, representative in Congress from the Tenth Congressional district, on December 3 at 5 p.m. The meeting was held in the W. S. Major Hospital, Shelbyville. Congressman Harvey spoke on probable federal legislation of interest to the medical profession. Dinner was served in the hospital to 14 members. The regular December meeting was held in Alcazar on December 9 with Dr. J. A. Hetherington, Indianapolis, as guest speaker.

A business meeting preceded the November 11 meeting of the society which was held in the Elks Home, Shelbyville. Eighteen members attended the dinner meeting. A special tribute was paid to three members of the society, Dr. Sewell B. Coulson, Waldron, Vernon C. Patten, Morristown, and Dr. Emerson Barnum, Shelbyville, who have practiced a total of more than 150 years. Dr. H. H. Inlow introduced the three veteran physicians who responded with some reminiscences of their early years in practice.

---

Representatives of Blue Cross were special guests at the November 19 meeting of the **Steuben County Medical Society** which was held in the Sunset Hotel at Crooked Lake, near Angola. Eight members attended the dinner meeting after which a film was shown to clarify some of the problems under discussion by the Blue Cross speaker.

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A wire recording of a discussion on "Care of the Pre-School Child" was programmed by the **Sullivan County Medical Society** for their dinner meeting November 5 in the Sullivan Hotel. Ten members were present.

---

Varied action was taken by members of **Tippecanoe County Medical Society** at their

dinner meeting November 9. Dr. L. C. Smith, president, named Drs. Cole, Rommel and Hughes as the nominating committee and instructed them to report at the next meeting. Resolutions were read in honor of Dr. Ray Ikens and Dr. J. W. Shafer, whose deaths had occurred since the previous meeting. It was voted to cooperate for the third year with the biology department of Jefferson High School, Lafayette, and to provide a panel of physicians to appear before the students early in 1954. Blue Cross representatives were present and conducted the scientific program, showing a film on increasing hospital care costs.

At the October meeting of the society Congressman Charles A. Halleck, Rensselaer, was the speaker. A question and answer period followed.

Election of officers for the **Washington County Medical Society** and Washington County Memorial Hospital staff was the sole

business transacted by the six members who attended the December 8 meeting in the hospital.

The next meeting was scheduled for January 12 in the Washington County Hospital.

Thirty-five members of **Wayne-Union County Medical Society** elected officers for 1954 at a dinner meeting in the Leland Hotel, Richmond, on December 10. The next meeting will be held January 14.

"Current Drugs Used in the Treatment of Hypertension" was the title of the paper given by Dr. Richard Griffith, Indianapolis, before 40 members of Wayne-Union Medical Society in the Leland Hotel, Richmond, on November 12. Dr. James W. Denny, Indianapolis, chairman of the Medical Education Fund for the Indiana State Medical Association, explained the need of medical schools for financial assistance and the plan to meet that need from within the medical profession itself. James A. Waggener, executive secretary of I.S.M.A., spoke on "The Role of Medical Men in State and National Affairs."

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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced, with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Only a limited number of illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication of THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

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NUMBER 2

### ELECTROCARDIOGRAPHIC CHANGES DURING GENERAL ANESTHESIA

CHARLES FISCH, M.D.

MERLE E. PICKETT, M.D.

ROBERT B. FAILEY, Jr., M.D.

*Indianapolis*

GENERAL ANESTHESIA, since its introduction into surgical practice more than 100 years ago, has been the stimulus to much investigation regarding the response and tolerance of the heart to surgical and anesthetic procedure. The electrocardiograph has been among the many agents used in the study of the cardiac response to surgery and anesthesia. This study has been facilitated by the use of the several newer type machines which permit continuous visual observation of the electrocardiogram, rapid switching of leads, and instantaneous recording of any changes observed. The authors of the present paper have had opportunity to make this study in a small series of cases, and it is their

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purpose to report on these and to review the subject of electrocardiographic change in general anesthesia.

#### METHOD AND MATERIAL

Twenty-six patients undergoing a variety of surgical procedures were employed in this study. The only special consideration in selection of patients was the exclusion of open thoracotomy cases and of operations involving surgery of the head and neck. As seen in table I, ages ranged



TABLE I

Age	Sex	Anesthetic	EKG Changes				
			Rhythm	QRS	S-T	T	Q-T
53	F	G.O.E.	Nodal rhythm A-V dissociation Parasystoles		depressed		
11	F	G.O.E.	Nodal rhythm Nodal tachycardia A-V dissociation Parasystoles		depressed	inverted	prolonged
72	F	G.O.E.	Cardiac arrest		depressed		
70	M	G.O.E.	Aur. tachycardia				
27	F	G.O.E.				lowered	
64	M	G.O.E.	Absent P waves		sagging	lowered	
25	F	G.O.E.	A-V dissociation		sagging	lowered	
80	F	G.O.E.	A-V dissociation	LBBB*			
74	F	G.O.E.	A-V dissociation	RBBB**			
34	F	G.O.E.	A-V dissociation				
38	F	G.O.E.	Absent P waves Nodal rhythm				
42	F	G.O.E.	Aur. premature A-V dissociation		sagging		
55	M	G.O.E.	A-V dissociation			inverted	
52	M	G.O.E.	Absent P waves A-V dissociation				
15	M	G.O.E.	Absent P waves				
60	F	G.O.E.	Aur. Bigeminy				
25	F	G.O.E.	Vent. Prematures				
32	F	G.O.E.				inverted	prolonged

\* LBBB—Left bundle branch block.  
 \*\* RBBB—Right bundle branch block.

from 11 to 84 years, and sexes were fairly evenly divided. No attempt was made to select cases with regard to cardiovascular status, and the series includes normals as well as those with cardiovascular disease.

Equipment consisted of a Cambridge operating room cardioscope. This apparatus includes a direct-writing electrocardiograph and in addition a cathode ray oscillograph permits continuous visualization of the electrocardiographic tracing on a glass screen. With this machine control tracings were taken on all patients prior to induction of anesthesia. From this point the electrocardiogram was observed continuously on the glass screen, and tracings were recorded instantaneously whenever any abnormality or sig-

nificant change was observed. As noted in table I, the anesthetic was invariably an inhalant, gas-oxygen-ether in most cases, cyclopropane-ether in two. Morphine and atropine in standard dosage were given preoperatively.

RESULTS

In table I are shown the results of this study. As may be seen 18 of the 26 individuals observed showed electrocardiographic change of a sort which might be considered abnormal. These changes consisted of a variety of premature complexes arising from different foci in the heart and of blocking of the electrical impulse occurring at several points in the conduction system. In combination, these phenomena resulted in

several types of electrocardiographic dissociation. There were in addition sagging and lowering of the ST segment, lowering and inversion of T waves, and prolongation of the QT interval. These changes were in general a feature of the induction phase rather than of deep anesthesia. There was no obvious correlation between associated heart disease and the observance of electrocardiographic change. Within the limits of the present study it was not possible to establish any relationship between anoxia and occurrence of electrocardiographic change, although the impression was obtained that individuals having the greater degrees of respiratory disturbance during the period of induction were more apt to show electrocardiographic change.

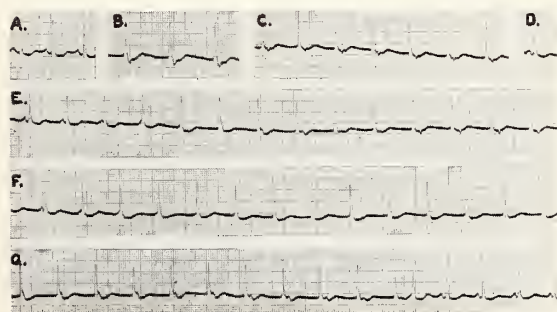
Figures 1 through 5 illustrate some of the more interesting electrocardiographic features observed in this series. Since our group of individuals studied was far from heterogeneous, and surgical procedures were quite varied, no information of a statistical nature can be obtained from them. They do illustrate, however, the wide variety of changes which may be seen in a random series of electrocardiographic tracings taken on individuals under general anesthesia. Of the examples shown only that in Figure 3 was from an individual having clear-cut heart disease. Among several of the older individuals some degree of hypertension was noted, but in our subjects this condition of itself appeared to have no influence on the incidence of electrocardiographic abnormalities.

Figure 1 shows selected portions of a continuous electrocardiogram having as its essential feature a disorder of the cardiac rhythm. Ex-

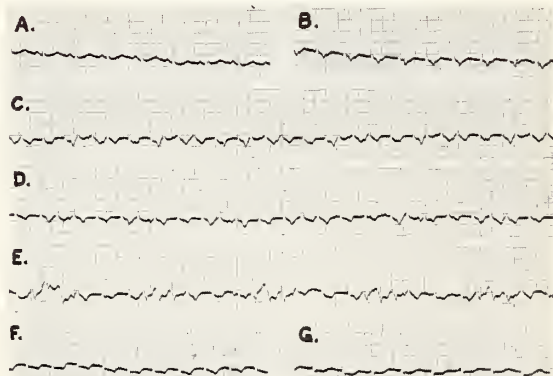
amples shown, excepting the control, were taken during induction. Sections B and C (nodal rhythm) show the auriculo-ventricular node as the dominant control of cardiac rhythm, replacing the sino-auricular node in the normal control. In section E both foci appear to be active with a complete dissociation of their effects. In F the normal (sino-auricular) focus is completely inactive, and the mechanism is entirely that of the auriculo-ventricular node. In G there is almost complete dissociation of the two foci with the auriculo-ventricular node behaving as a parasystolic focus. The various changes here reproduced were selected from a continuous strip recorded over a period of approximately 10 minutes during induction of anesthesia.

Figure 2 likewise illustrates various forms of dissociation of the two nodal foci controlling cardiac rhythm, as they developed during induction of anesthesia. Sections F and G here also show distinct lowering of ST segments, inversion of T waves, and prolongation of QT interval. These three changes were observed toward the end of a long period in which the cardiac rhythm was abnormal. Their actual cause is uncertain and possibly includes several influences, notably generalized anoxia due to breath holding, mucous, or broncho-spasm, local anoxia of heart muscle resulting from insufficient coronary artery flow during the period of arrhythmia, or possibly some electrolyte imbalance of which hypo-potassemia appears not unlikely. Recent

**Fig. 1.** Patient, a 53 year old female, Ruptured ulcer . . . (B) and (C) shows nodal rhythm, (D) Return to normal rhythm, (E) Auriculoventricular dissociation with change in site of origin of auricular pacemaker, (F) A-V dissociation with disappearance of P waves, (G) A-V dissociation with a parasystolic focus.



**Fig. 2.** Patient, an 11 year old female, Appendectomy . . . (A) Control, (B) Nodal rhythm, (C-D) A-V dissociation with parasystoles, (E) A-V dissociation with runs of nodal tachycardia, (F) Sagging S-T segment and inversion of T waves, No demonstrable P waves, (G) Sagging S-T segment, inverted T waves, prolonged Q-T interval and no demonstrable P waves. (Changes in (G) somewhat similar to potassium deficiency pattern.)



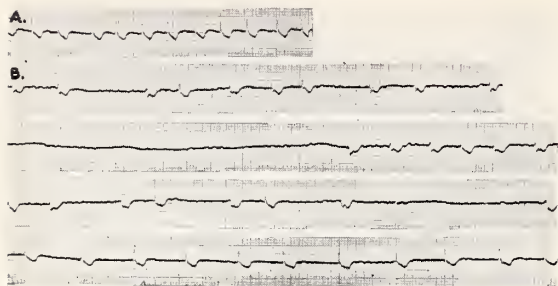


Fig. 3. Patient, a 72 year old female. Simple mastectomy . . . (A) Control showing auricular fibrillation. Digitalis effect. The remainder of the tracing shows slowing of ventricular rate with cardiac standstill. Note marked depression of S-T segment.

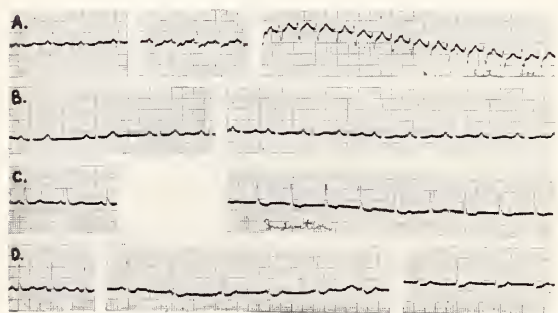


Fig. 4. (A) Patient, a 70 year old male. Control tracing, sinus tachycardia and finally auricular tachycardia. (B) Patient, a 27 year old female. Pelvic laparotomy. Control tracing with subsequent lowering of T waves. (C) Patient, a 64 year old male. Control tracing. Absence of P wave, sagging of S-T segment and lowering of T waves. (D) Patient, a 25 year old female. Pelvic laparotomy. Control tracing. A-V dissociation with sagging of S-T segment and lowering of T waves. No identifiable P waves in last segment.

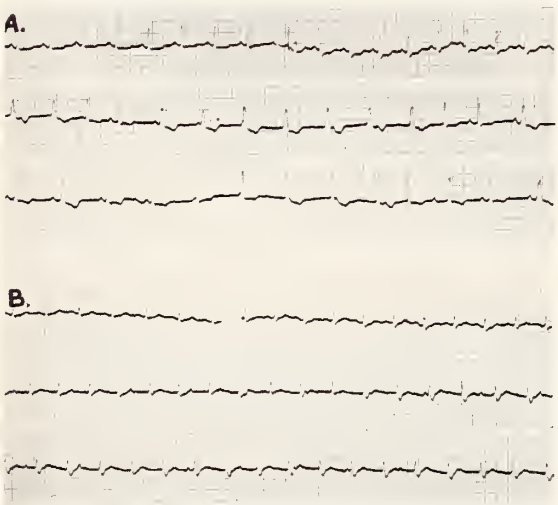


Fig. 5. (A) Patient, an 80 year old female. (A-1) Control tracing and a sinus tachycardia. (A-2-3) shows a A-V dissociation with intermittent left bundle branch block. (B) Patient, a 74 year old female. (B-1) shows a control tracing and incomplete right bundle branch block. (B-2-3) shows A-V dissociation and intermittent complete right bundle branch block.

evidence suggests that hypoxia results in pulmonary arterial hypertension which in turn causes right heart "strain" and may account for ST and T wave changes.<sup>1</sup>

Figure 3 appears to show an example of complete suppression of activity of the auriculo-ventricular node. Since this individual suffered from irreversible auricular fibrillation of long duration, complete suppression of the auriculo-ventricular nodal mechanism without activation of any new focus in the ventricle resulted in cardiac arrest. (Following this episode anesthesia and surgery were continued, and the patient never appeared harmed by her experience.)

Figure 4 shows in section A (top line) the development of sinus tachycardia and subsequently of auricular tachycardia. The other three sections in this figure taken from different patients show features essentially like those seen in more detail in Figures 1 and 2.

Figure 5 shows in section A a tracing which has as its special feature the development of intermittent left bundle branch block, while section B illustrates a right bundle branch block.

## DISCUSSION

As shown in Table 1 of this paper 18 of our 26 cases developed some form of electrocardiographic abnormality while under general anesthesia. This incidence is similar to that observed in several other published series of cases in which the incidence of abnormalities observed is at least 50%.<sup>2</sup> This figure is subject to considerable variation and depends on many factors, among which are the age and race of the patient, type of operation performed, anesthetic agent employed, pre-anesthetic medication given, and extent of electrocardiographic observation.

Under any consideration development of electrocardiographic change at variance from normal standards must be considered a normal rather than a pathological feature of the induction of general anesthesia. It is a feature, however, which assumes importance when viewed in relation to the rare operative case in which sudden and unexpected death occurs apparently as a result of cardiac arrest. In the past there has been a tendency to attribute such fatalities to ventricular fibrillation and to make an object of special concern the surgical patient in whom organic heart disease has been shown to co-exist.



In actuality the cause of unexpected death under anesthesia probably arises in a somewhat different manner. Primarily it has been shown that as a true cause of death ventricular fibrillation is relatively uncommon.<sup>3</sup> Many of the older texts on anesthesia devote considerable space to discussion of death from this cause. It is interesting to observe, however, that examples cited are most commonly not in elderly individuals with organic heart disease but are much more frequently those of children or of young adults in whom cardiovascular disease was not previously suspected. An additional consideration is that of all operations frequently performed, that most often complicated by unexpected death is tonsillectomy—an operation most often performed upon young, reasonably healthy children.<sup>4</sup> Additional considerations are that in tonsillectomy anesthesia is characteristically light and pre-anesthetic medication of small dosage.

In view of the foregoing observations, conditions unlike those typically associated with primary myocardial disease appear to be responsible for electrocardiographic change under anesthesia and for the occurrence of sudden cardiac deaths during anesthesia. Primarily these alterations seem to depend not on the heart itself but upon abnormal activity of certain extra-cardiac reflexes which influence cardiac rate and rhythm. In man and in various animals there have been shown to exist a wide variety of these reflexes whereby stimulus of a peripheral nerve ending results in the discharge of central autonomic nervous impulses so as to influence heart rate or rhythm. The most selective of these are parasympathetic in type; among these an example is the reflex of the carotid sinus. By this reflex transient hypertension or pressure on the end organ situated at the bifurcation of the carotid arteries causes reflex vagal slowing of the heart. As this is observed with the electrocardiogram there frequently are seen various types of block such as prolonged PR interval, and disappearance of P waves.<sup>5</sup> Occasionally conduction is also blocked at the auriculo-ventricular node. The electrocardiographic result being either a transient complete heart block or a compensatory idioventricular rhythm. The clinical result is frequently that of syncope, occasionally convulsions, and if uncorrected, the theoretical result of sudden cardiac death.

The example of the carotid sinus reflex is

cited as one of the best understood of these reflexes. Others exist with "trigger points" especially in the head, neck, and upper bronchial tree where nerve supply is particularly abundant and sensitive and vital organs are exposed to the external environment. Surgical procedures requiring contact with structures in these areas are somewhat more apt to trigger reflexes than are those performed in less sensitive regions.

Besides specific stimulus of reflex cardiac inhibition, certain other influences have the general effect of increasing reflex activity. Excitement and apprehension appear to do so, so that poor preoperative preparation and inadequate sedation of patients prior to operation may increase the chance of reflex cardiac arrhythmia. Under general anesthesia the higher centers of nervous activity are those first anesthetized. This has the effect in induction of anesthesia of allowing the lower autonomic centers to act uninfluenced by the inhibitions of the higher centers. At this time through struggling, choking, increased mucous, breath holding, etc. transient anoxia is apt to occur.

A summation of these influences during the induction phase of anesthesia appears to bring about the various electrocardiographic changes previously illustrated, and occasional fatalities due to cardiac arrest would seem to result from the same mechanisms. In the prevention of these incidents, which represent extreme and unexpected emergencies, prophylaxis rather than treatment is the logical approach. Good preoperative sedation, adequate oxygen, and during induction the avoidance of manipulations that may trigger reflexes are all important. Atropine in small doses tends to stimulate the parasympathetics in the intact animal and in this situation is potentially harmful. In large doses it has an opposite effect and so is useful in inhibiting mucous in air passages and in depressing vagal influences on the heart. Since the toxic dose of atropine is very large, there is no risk in adequate atropinization. It is possible that in the future one or more of the newer synthetic parasympatholytic drugs may replace atropine in this use; to date, however, sufficient experimental evidence is not available. By another means intravenous procaine and its derivatives, procaine amide (pronestyl) and diethylaminethanol, reduce the incidence of cardiac arrhythmias by inhibiting vagal effects, and as prophylaxis they have been demonstrated as useful.

Regarding the therapeutic use of drugs it should be observed that digitalis preparations tend to stimulate the ventricular myocardium and to depress the cardiac conduction system. Digitalis also appears to render more active the reflex of the carotid sinus.<sup>5</sup> Since its clinical usefulness is in the treatment of cardiac insufficiency and not in treating any type of cardiac arrest, its place in handling anesthetic emergencies is extremely limited. The situation is very similar concerning quinidine. This drug has as its primary use the treatment of ventricular tachycardia; it tends to cause heart block, and it is of little use in controlling arrhythmias not arising primarily in the myocardium.

Regarding anesthetic agents, chloroform and ethyl chloride have a specific stimulating effect on the ventricular myocardium and should be used with care, particularly when epinephrine or other sympathomimetic drugs may be needed. While these drugs do not have a specific influence upon the vagal cardiac reflexes, they do not have any less effect than other inhalants and in addition are apt to produce ventricular arrhythmias in a heart with already disturbed rhythm.

Finally, the combination of local procaine and a general anesthetic or of curare and a general anesthetic would appear to be poor practice in regard to the production of cardiac arrhythmias and reflex cardiac arrest under circumstances when tissue oxygenation is not optimal. These

combinations of drugs have the effect of making possible surgical manipulations at levels before deep anesthesia is reached. As has been described, reflex activity is at its height during light anesthesia, and under such circumstances the danger of cardiac arrest is great.

### Summary

1. Eighteen of a group of 26 individuals under continuous electrocardiographic observation during general anesthesia developed significant electrocardiographic change at some time during the procedure.

2. These changes appeared to result from release of extracardiac reflexes rather than from a primary cardiac cause.

3. The relationship of sudden cardiac death during anesthesia to the type of electrocardiographic change observed is discussed.

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## IATROGENIC MENINGITIS

The authors present two well studied cases and review the literature of bacterial meningitis occurring as a complication of lumbar puncture. Such infections have been reported following diagnostic lumbar punctures, spinal anesthesia and air injection for encephalography. Most infections have involved gram negative organisms from the skin surface, most commonly *Pseudomonas Aeruginosa*. In the usual case a low grade meningitis appears anywhere from 12 hours to 10 days following a spinal puncture. Infection tends to be long lasting and is characterized by remission and relapses. The authors stress that the investigative work indicates that penicillin may enhance the growth of these organisms and that therapy should be deferred until the organism has been identified and drug sensitivity tested. The presence of *Pseudomonas* can be quickly identified by irradiating the spinal fluid with ultraviolet light, bringing out the fluorescent characteristic of this organism.

Cutler, Milton and Cutler, Paul: Iatrogenic Meningitis. *Jour. Med. Soc. N. J.* Vol. 50, p. 510-513, November, 1953.

# REPAIR OF AN ARTERIO VENOUS FISTULA OF THE COMMON CAROTID ARTERY TO THE INTERNAL JUGULAR VEIN: A Case Report

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THE LARGER blood vessels are for the most part of their extent so placed that they are somewhat protected by the less vital structures. Only at a relatively few points are they in such relation that the pulsations in the arteries can be palpated. In the axilla, groin and along the neck some very important large arteries and veins are rather superficially placed. Because of these relationships, vessels in these areas are the site of serious injury more frequently than in others. A review of cases reported, however, indicates that relatively seldom are these vessels damaged appreciably by contusion or stretching, and the serious injuries to them result most often from penetrating wounds, such as a stab wound or gunshot wound.<sup>1, 2</sup>

To the layman the most frightening and spectacular aspect of a wound is the hemorrhage resulting. Its real danger, however, must be estimated by the actual blood lost or the interruption of the blood flow to the region. Emergency surgical care has been directed to correct these dangers, and for the most part has consisted of ligation of the smaller vessels and a repair of the larger ones.

Penetrating injuries of the neck are particularly hazardous because of the size of the vessels, the proximity to the heart and the consequent high arterial pressure there, and the very frequent impairment of circulation in the head. Although the vessels of the neck are for the most part bilateral, it seems that collateral circulation from one side to the other is not always adequate. When the arterial channels to one part of the neck are occluded, symptoms of inadequate circulation in the head frequently develop. Heringman, Rives and Davis<sup>3</sup> conclude that any ligation of the larger arteries will be followed by a diminished blood supply to the part.

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The anatomical relationship of the common carotid artery and the internal jugular vein seems to predispose to the development of an arterio venous fistula following a penetrating injury. A review of cases indicates that this development may be progressive and presents hazards to the heart as well as to the circulation in the head. This increased heart load is a result of diverting a great quantity of blood into the venous system, thus greatly increasing the venous pressure.<sup>4</sup>

Also, other arterio venous fistulas are found in the neck and are possible wherever a large artery and vein are in close proximity. Diagnosis of the exact location is often mistaken, and the surgeon should always be able to change the procedure to meet the vessel involved.<sup>1</sup> The repair of the arterio venous fistula of the common carotid to the internal jugular vein has been carefully studied as a part of a series of 101 cases by Seeley, Hughes, Cook and Elkins<sup>5</sup>. In this review of cases done at the Vascular Center of the Walter Reed Hospital, four cases of carotid artery fistula were found. Three of these were of the common carotid artery to the internal jugular vein. The results of this study seem to recommend an attempt to repair these vessels by resection of the fistula and by end to end anastomosis of both artery and vein.

Gius and Grier<sup>6</sup>, however, recommend that a ligation or excision of the jugular system is



practical. They state that there is always adequate venous collateral circulation in the vertebral plexus of veins even when a bilateral resection of the jugular system is done.

Penick<sup>7</sup> emphasizes that a vein should never be repaired when the corresponding artery has been ligated. No repair of the artery may be attempted when it can be ligated, and he thus stresses the procedure of choice to be the quadruple ligation and excision of the arterio venous fistula even as applied to the common carotid artery.

Singleton and Singleton<sup>8</sup>, however, emphasize the hazard of such a ligation of the common carotid artery and report as follows: "Quadruple ligation has been the general method of attack in these lesions, but more recently there has been an increasing effort to restore the continuity of the artery despite the greater technical difficulties in an endeavor to prevent cerebral anemia which so frequently occurs following ligation. Interruption of the internal carotid, and especially the common carotid, has long been known to be hazardous. In Zimmerman's series of 70 ligations of the common carotid artery 26% had cerebral symptoms. In Pitz' series of 600 cases, there were 32% showing severe cerebral symptoms."

These authors further point out, however, that any alteration in the circulation may have peripheral effects, and as an example cite a case where the common carotid artery circulation was restored in a 49 year old man with immediate post-operative cerebral hemorrhage apparently due to the increased pressure in the circle of Willis.

Elkin<sup>9</sup> emphasizes the importance of trying to carefully estimate the adequacy of the collateral circulation before ligation of a large artery. He further stressed the importance of obliteration of collateral arteries to the fistula after the method of the Matas operation.

After study of a series of cases of arterio venous fistula in the carotids, Mason<sup>10</sup>, Albright and Van Hale<sup>11</sup> conclude that the quadruple ligation with the excision of the fistula should almost always be done.

Bigger<sup>12</sup> states that arterio venous fistula is seldom cured except by complete excision of the fistula with either ligation of the vessels or a suture of the artery involved. Although there

may be sufficient collateral circulation to maintain life, it does not prevent circulatory difficulty when major vessels are ligated or resected. It is therefore suggested that when such important vessels as the common carotid artery and jugular vein are the site of an arterio venous fistula, transverse repair of the artery should be employed if there are no contradictions. He further points out that one of the strongest contraindications to arterial suture is calcification in the wall of the artery.

Elkin<sup>13</sup> reporting on a study of 450 cases of arterio venous fistula in general concluded that, "In general, arterio venous fistula has been treated most frequently by quadruple ligation and excision of the fistula, although in 12 instances it has been possible in this series of cases to repair the fistula and preserve the continuity of the artery. The latter course is preferred, but it is usually impossible because of dense scar tissue due to previous infection and the usual presence of a false sac."

A review of the experiences and opinions of these authorities seems to lead to the conclusion that the procedure seems to be somewhat controversial and must be greatly altered by the individual factors in the case. Most seem to agree, however, that a restoration of the arterial blood supply is preferable if such can be safely and permanently affected. The following is a case report in which such seems to have been possible, with a good recovery.

## CASE REPORT

B.H., a colored male, age 50, was first examined January 21, 1952. His complaint was that of shortness of breath, palpitation and a sense of compression in the left side of the neck with a pulsating swelling there. He explained that these symptoms were much more severe during activity and in his work which was particularly arduous, being an iron molder, he was having increasing difficulty.

In review of his past, he stated he had had the usual childhood diseases with good recovery from all. He had had no serious illness or accident until 21 years ago, at which time he received a gunshot wound in the neck. He explained that this was from a small calibre, apparently No. 22, revolver and that the wound healed uneventfully. He first noticed a swelling in the neck which was slight in extent some three



Photograph of patient showing tumor mass in the neck.



Similar photograph showing fistula occluded by digital pressure and venous sac emptied.

or four years later, but this remained without significant change or without symptoms until a few months previous to his first examination, at which time the tumor mass began to increase in size and the pulsation apparently became more prominent in it. These symptoms steadily increased.

Examination showed him to be a rather slender, colored male, apparently in moderate respiratory distress. There was no abnormality of significance except a pulsating tumor mass in the left side of the neck which was easily compressible and which when compressed could be obliterated by digital pressure at a point just anterior to the edge of the sternocleidomastoid muscle and at a point about three inches above the clavicle. Upon release of this pressure the tumor rapidly reappeared. A thrill was palpable over the tumor mass and a loud, continuous bruit was heard over it.

The radial pulse was 80, and the brachial blood pressure was 155/80. Blood and urine examination showed no evidence of disease, and a Kline and Kahn test was repeatedly negative.

He was hospitalized for operation on January 22, 1952, and the following day under general anesthetic of ether and cyclopropane, the tumor mass was explored through an incision extend-

ing from the angle of the jaw and curved along the anterior border of the sternocleidomastoid muscle. The deep fascia was incised and an arterio venous fistula involving the common carotid artery and the internal jugular vein was found. This appeared to arise along the common carotid artery over an area about an inch and a half long and about one inch below the bifurcation of the artery. The internal jugular vein was greatly distended to a diameter of approximately five inches in its greatest diameter and all tributaries were correspondingly distended so that a large venous pool was exposed. The artery was dissected free from all of its attachments and scar tissue from the level of the clavicle to well beyond its bifurcation. The common carotid artery was then encircled twice at points above and below the fistula with umbilical tape. This tape was then clamped by hemostat just tightly enough to occlude the blood flow after the method of Thurston and Lamb.<sup>14</sup> Great care was taken to apply just enough force to occlude the blood flow. The veins were then compressed and smooth clamps placed across the large venous sac and the fistula's opening then resected from the artery. When thus the artery was opened, it was thoroughly irrigated with a one-half of one percent of sodium citrate solution and this followed with a heparin solution to



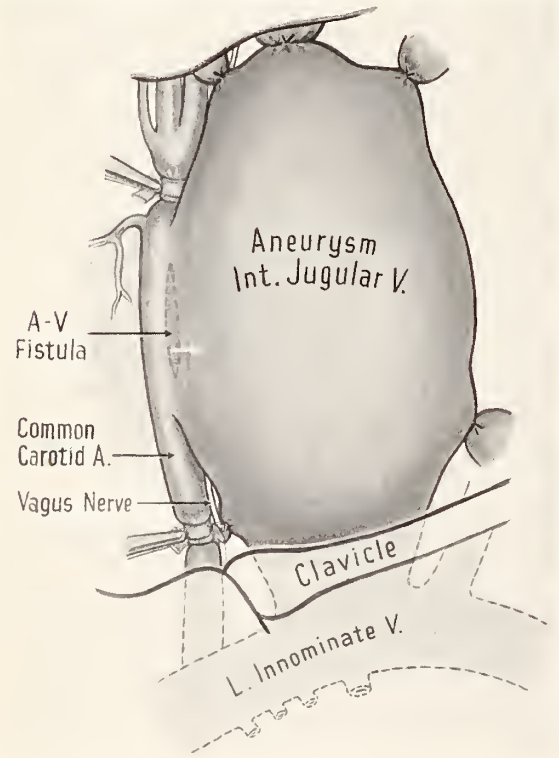


Photograph at operation showing anterior portion of venous sac.

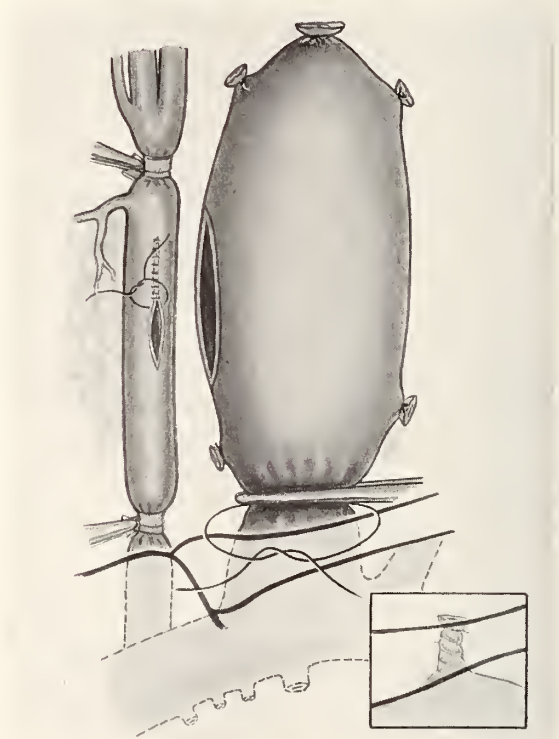


Photograph at operation showing artery occluded, retracted medially and venous sac collapsed.

Artist's conception of relation and comparative size of common carotid artery and internal jugular vein.



Artist's conception of common carotid artery and internal jugular vein showing fistulous tract severed, venous channels ligated and suture of artery wall. Insert—showing manner of closure of stump of internal jugular vein.





insure against clotting in the open artery. Just enough tissue was removed so that when the arterial edges were approximated along the longitudinal axis that the artery would maintain its original lumen. This defect in the arterial wall which was then about an inch and a half long was closed with 15 fine, silk sutures passing entirely through the arterial wall and suturing intima to intima. As soon as this suture was completed, the umbilical tapes were removed, the distal tape being removed first, and then the proximal tape. There was only very slight bleeding at the suture line and this persisted for only 4 or 5 heart beats. A temporal pulse was immediately felt and it was certain that blood was passing through the artery at the point of suture. It was then covered loosely with the fascia and further attention given to the greatly dilated veins. All tributaries of the large sacular portion were ligated with silk ligature. The vein was then freed from its attachments and elevated and dissected free down to below the clavicle near its junction with the subclavian vein. It was then clamped at this point, the stump rotated through 180 degrees and doubly ligated with medium silk ligature. This was then fixed in this slightly rotated position to the deep fascia. The wounds were then irrigated with saline solution and the fascia closed loosely. The skin was approximated with interrupted silk suture and a soft dressing applied.

His post-operative condition was good and he made an uneventful recovery so far as the surgical wound was concerned. He was discharged from the hospital on January 29, 1952, in good general condition and without any cerebral symptoms. He returned to his work as an iron molder about one month after the operation, and when last seen for examination on January 23, 1954, stated he had no complaints. The neck appeared normal in contour and there was a normal pulsation palpable in the left temporal artery. Blood pressure was 140/80, and the pulse was 80. There was no evidence of any abnormality attributable to the effects of the pre-existing arterio venous fistula or the operation.

## CONCLUSION

1. From this short review of the literature, it would seem that, arterio venous fistulas of the larger vessels are of danger because of their

increased load on the heart resulting from the increased venous pressure. They are also dangerous to regions because of a diminished blood supply to that region. Arterio venous fistulas of the smaller vessels are of no significance unless they happen to involve locally some vital structure.

2. It would seem that the treatment in the past has been largely that of ligation, usually quadruple, and this frequently followed by excision of the fistula. Simple ligation may result in recurrence due to collateral circulation into the arterial venous fistula tract.

3. In those cases where circulation has been restored in an arterio venous fistula, it has usually been by resection of the fistula and end to end anastomosis of the artery. The veins seem less important; however, unless adequate circulation can be re-established in the artery, its corresponding vein should be ligated and possibly resected.

4. The present case report represents a case in which a large arterio venous fistula from the common carotid artery to the internal jugular vein was resected and the artery sutured with a longitudinal suture about an inch and a half long. The patient has made an uneventful convalescence, and in a reasonably short time returned to relatively arduous work. Normal circulation in the artery seemed to be restored immediately, and this remained unchanged when last seen which was approximately two years after the operation.

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## ASTHMA IN THE FIRST YEAR OF LIFE

This article stresses the importance of asthma appearing in early life emphasizing that the asthma that appears at this early age is likely to be more severe than that coming on later. Differential diagnosis of wheezing, the type of skin testing, the manipulation of the diet, symptoms and specific treatment are all well presented. Discussion following the article brings out well the controversial elements in the handling of this condition.

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## ADVANTAGES OF ELECTROCARDIOGRAPHY DURING SURGERY OUTLINED

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*Bluffton*

**T**HE USE OF ELECTROCARDIOGRAPHY in surgery is not new but its advantages are not generally appreciated. Electrocardiographic studies during anesthesia have been reported by several authors<sup>1-5</sup> using string electrocardiographs. The advent of commercially available direct writing electrocardiographs in recent years has made possible much closer observation of the cardiac status of anesthetized patients.<sup>6</sup> We have recorded electrocardiograms on most major surgical patients since 1950 using this type of instrument at first. These electrocardiographs are adaptable for use in the surgery of any hospital by obtaining slightly longer patient lead cables. In the past eight months we have used a continuously writing cathode ray scope built especially for the operating room.\*\* We have been greatly impressed with the valuable assistance electrocardiograms provide during anesthesia.

The electrocardiogram allows early detection of cardiac arrhythmias arising during surgery and establishes the exact nature of the arrhythmia. Taylor<sup>7</sup> in 1941 reported an incidence of only 6.5% arrhythmias detected by clinical means in a large series of patients under cyclopropane anesthesia. Others<sup>5</sup> using the electrocardiograph

have detected a much higher percentage of arrhythmias. Even the most skilled anesthetist has difficulty determining the exact nature of most arrhythmias from the character of the pulse alone and often the type of therapy depends on the type of arrhythmia present. It is difficult to detect the onset of cardiac arrest with certainty except during thoracotomy. The electrocardiograph demonstrates this immediately so that cardiac massage can be instituted without delay. Figure I A shows electrocardiograms of a patient who was revived after cardiac arrest.

The electrocardiograph also acts as a guide in treating these arrhythmias. Perhaps the greatest usefulness of electrocardiograms during surgery is their aid in the treatment of the more serious arrhythmias which might otherwise result in cardiac arrest. We have used intravenous procaine and quinidine in treatment of these arrhythmias and at times have found it necessary to change the anesthetic agent. Figure I B, Figure II C, D, and E show the effect of intravenous drip of 0.1-0.2% procaine on arrhythmias induced during surgery. Figure II F illustrates the restoration of a patient to normal sinus rhythm following change of anesthetic from cyclopropane to ether.

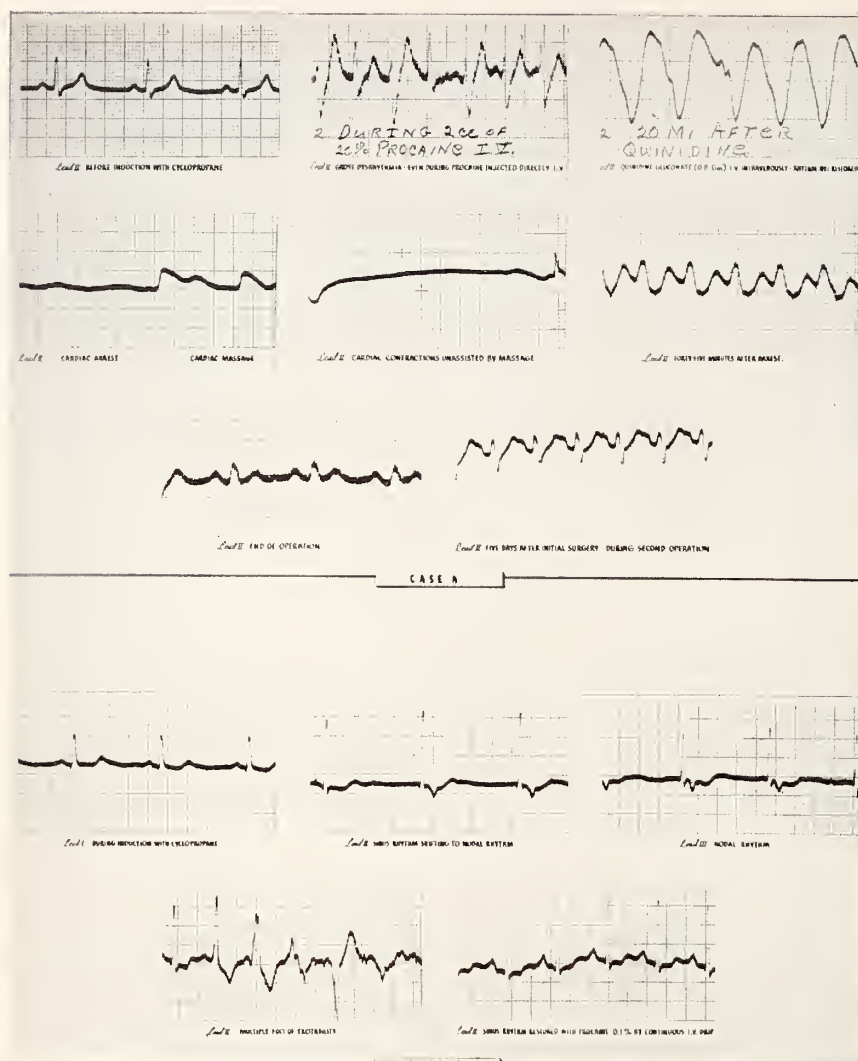
The use of the electrocardiograph during surgery has a further advantage in that it enables the anesthetist to better evaluate various anesthetic agents regarding their potentialities in inducing cardiac arrhythmia. Charts I and II summarize our experience with cyclopropane and

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Presented as an exhibit at the Annual Session Indiana State Medical Association, October, 1952.

\*\* Cambridge Cardioscope.





nitrous oxide-ether anesthesia regarding arrhythmias induced.<sup>8</sup> Note that only 9% of the 221 patients under nitrous oxide-ether anesthesia had any arrhythmia whereas 62% of the 113 patients under cyclopropane had some type of arrhythmia. We feel that this demonstrates that arrhythmias may occur under both types of anesthesia but that they occur less often under ether than under cyclopropane anesthesia.

### SUMMARY

The advantages of electrocardiography during surgery may be summarized as:

1. Early detection of cardiac arrhythmias.
2. Establishment of the exact nature of the arrhythmia.
3. Guidance of the treatment of arrhythmias.
4. Better evaluation of anesthetic agents regarding their potentialities in causing arrhythmias.

We feel that the electrocardiograph will come to be considered as standard operating room equipment in the near future as soon as its advantages become more widely recognized.

**FIGURE II**

**CASE C**

Lead II—Before induction with cycloprane

Lead II—Multiple ventricular premature contractions

Lead II—Sinus rhythm restored by procaine 0.2% by continuous i. v. drip

**CASE D**

Lead II—Before induction with cycloprane

Lead II—Pulsus bigeminus

Lead II—Sinus rhythm restored with procaine 0.1% by continuous i.v. drip

**CASE E**

Lead II—Before induction with cycloprane

Lead II—Multiple and multifocal ventricular premature contractions

Lead II—Sinus rhythm restored with procaine 0.1%

**CASE F**

Lead II—Before induction with cycloprane

Lead II—Gross dysrhythmic

Lead II—Atropine Gr 1/100 i.v. improved but did not restore rhythm

Lead II—Sinus rhythm restored three minutes after conversion to ether anesthesia

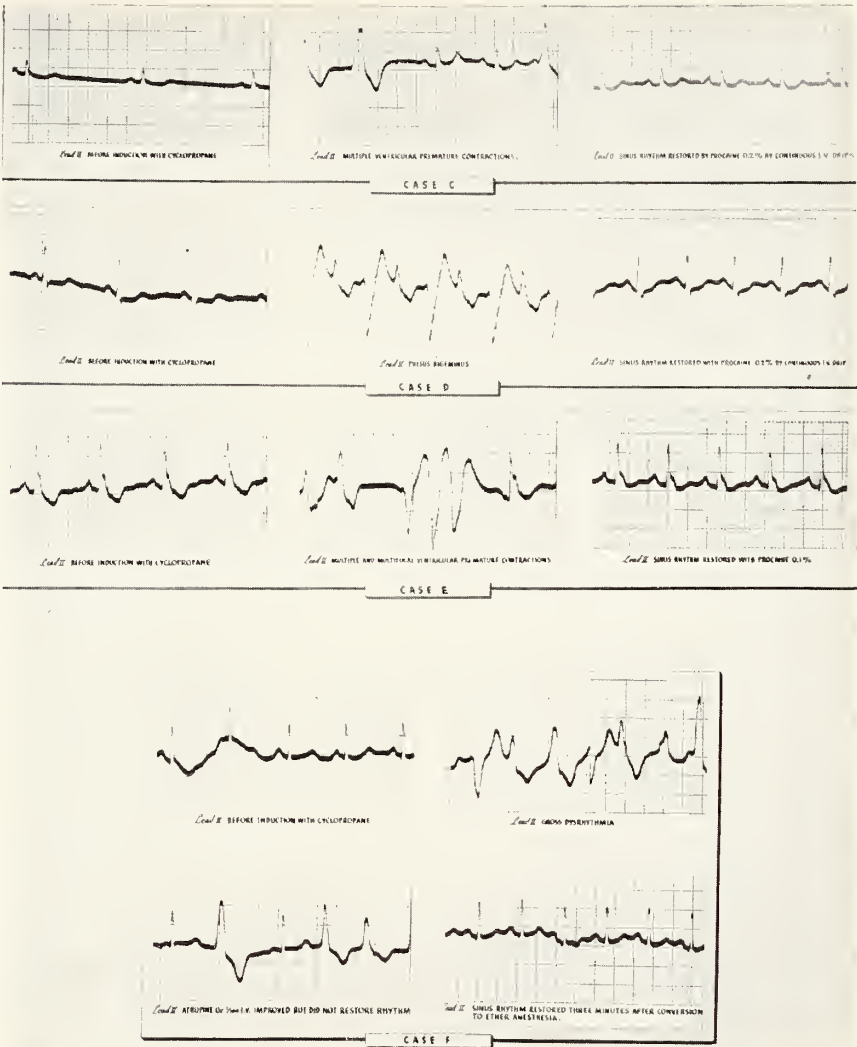


CHART I	
Type of Rhythm	Frequency
Ventricular rhythms -----	85
Multiple and multifocal ventricular premature contractions -----	41
Pulsus bigeminus -----	23
Occasional ventricular premature contractions -----	15
Ventricular tachycardia -----	3
Gross dysrhythmia -----	2
Ventricular fibrillation and cardiac arrest -----	1
Auricular rhythms -----	18
Auricular premature contractions -----	11
Wandering pacemaker -----	5
Auricular fibrillation -----	2
Supraventricular Tachycardia -----	2
Nodal Rhythms -----	9
Shift in pacemaker from sinus to A-V node -----	2
Nodal premature contractions -----	6
Nodal rhythm -----	1
Summary of the arrhythmias occurring in 70 (62%) of 113 patients under cyclopropane anesthesia.	

CHART II	
Ventricular rhythms (8 cases) -----	14
Multiple and multifocal ventricular premature contractions -----	4
Occasional ventricular premature contractions -----	6
Paroxysmal right bundle branch block -----	1
Ventricular tachycardia -----	1
Cardiac arrest -----	1
Pulsus bigeminus -----	1
Auricular rhythms -----	19
Wandering pacemaker -----	12
Prolonged P-R interval -----	4
Auricular premature contraction -----	2
Auricular fibrillation -----	1
Nodal rhythm -----	3
Summary of the arrhythmias occurring in 21 (9%) of the 221 patients under pentothal induced, nitrous oxide-ether anesthesia.	

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## ART STUDENTS HONOR DOCTOR

A doctor with more than 50 years service to his home community and a retired school superintendent shared honors during the Christmas season when art students of Seymour's Shields High School dedicated two simulated stained glass windows to them.

Dr. G. H. Kamman, a senior member of Indiana State Medical Association who is still in active practice, was selected for his outstanding service to Jackson county.

Each art student submitted a design and the final selections were composites of the best features. The simulated stained glass windows, placed at either end of the school's main hall, were 9 feet wide and 13 feet high, and were lighted each night during the holiday season for viewing by the passing public.

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# THE PRACTITIONER AS A UROLOGIST

ROBERT LICH, JR., M.D.\*

*Louisville, Kentucky*

WE ARE all acutely aware of the unrelenting pace of therapeutic medicine. This situation has created the need for more and more medical gatherings and necessitated our attendance. However, those of us in specialties must ever realize that our problem is minute compared to that of the practitioner. It is as true to-day, if not even more so, that the practitioner is the keystone in American medicine. Hence, it is the obligation of the specialist to acquaint the practitioner with the merits and limitations of each therapeutic and diagnostic procedure and interpret its sphere of application. It is with these fundamental considerations in mind that I appear before you.

First, let us discuss some current concepts in urology. What about the status of prostatectomy? I think that we can briefly say that the removal of large adenomata of the prostate should be done by open operation. In the medium to small prostatic hyperplasias the endoscopic or transurethral method is more advisable. The crux to the problem is that no matter what method of prostatectomy is chosen it is essential that all of the adenoma is removed. Transurethral resection is a method of the past for now we realize that it must be a transurethral prostatectomy if the result is to be what is anticipated; namely, permanent uncomplicated relief. With regard to the open method of prostatectomy, we have adopted the retropubic method because of its good operative visualization, positive hemostasis, minimal patient discomfort and uncontestably good results.

Cancer of the prostate has two distinct therapeutic facets. Operable cancer of the prostate is defined wherein a nodule of cancer is palpated

per rectum and the prostate is still freely movable. This cancerous prostate must be removed by radical prostatectomy (excision of the prostate, its capsule and the seminal vesicles) and the patient can anticipate at least a 50 percent chance of cure. Where else or in what other cancer can we offer the patient these odds? Furthermore, as more and more of these patients are sent to the urologist in the operable stage this figure of 50 percent will be elevated.

The other facet of malignant prostatism is that of inoperable prostatic cancer where the gland is irregular, stony hard and fixed by neoplastic extension. These patients, if suffering from vesical obstruction, can be relieved by cutting a transurethral groove (these are true resections) through the cancerous prostatic urethra, but this is no cure. Stilbestrol and orchiectomy have proven their palliative ability. Studies are now underway in the use of radioactive gold injected directly into the cancer and bilateral adrenalectomy also may find its place, but further clarification of this picture is necessary. After it is all said and done, the patient with inoperable cancer of the prostate has little more than a three year average life span.

Stilbestrol may give relief to the patient with obstructive symptoms from non-cancerous prostatic enlargement and its effectiveness is greater in the very aged. Its use is usually short lived and can serve a purpose only when its limitations are appreciated. And remember, with an operative mortality of less than 2 percent, it is only the very rare patient who should be denied the positive cure of prostatectomy.

Bladder cancer is still a subject that has not found therapeutic clarity. Its treatment is operative and the type of operative procedure must be left to the discretion of the attending urologist. I can say, as a urologist, that we find little enthusiasm for our results because as the years go on the results do not approach our expecta-

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Read before the Orange County Medical Society at the French Lick Hotel, April 7, 1953.

tions. In small bladder tumors we prefer to cut them out with a resectoscope and cut deep into the bladder muscle with little concern about going through the bladder wall. The patient has a condition far more serious than the potential hazard of a bladder perforation. If, by cutting deep, we can effect a cure it is worth the risk. Our personal results in the past six years with this method have been encouraging and it has the advantage of no mortality and low morbidity. In large cancers of the bladder more radical methods may be considered including excision of the entire bladder and transplantation of the ureters into the bowel. Here again, we feel that, in patients with far advanced disease and with great urinary symptoms, palliation by the use of uretero-sigmoidostomy is useful. These patients can be given a comfortable existence for the time they have left and our experience with this operation has been most gratifying to both the patient and the surgeon.

What about hyaluronidase in the treatment of urinary stones? Much has been said and written on this subject in recent months. At the present time this therapy presents several limiting factors such as, expense of the drug, the occurrence of 'drug fastness' and the need of ever greater doses, the need for daily injections for an indefinite period, and the observation of increased stone formation upon discontinuation of hyaluronidase. It is obvious that this method for dealing with urolithiasis needs further clarification and its benefits should be more distinctly defined.

Because the practitioner sees patients from day to day he must necessarily classify his patients into two main groups: (1) those individuals that he will treat and (2) those that he will refer for treatment. What constitutes the criterion for the latter group? In urology, it will be those patients presenting symptoms that suggest potentially serious diseases that demand early diagnosis and possible surgery. Such symptoms in urology are primarily four: (1) hematuria, (2) abnormal masses, (3) inability to void and (4) recurrent infections.

Hematuria, which is gross or microscopic and occurs in the urine initially, terminally, or throughout the urinary stream, is an omen of great importance and often serious. Recurrent hematuria irrespective of the interval between episodes may be the first symptom of death. Every patient with hematuria should have a

complete urological examination and, if necessary, repeated examination until a definite diagnosis is firmly and irrevocably established. Generally, the old rule of painful hematuria being inflammatory while painless hematuria is cancer is true, however, painful hematuria may be renal tuberculosis. Early diagnosis and surgical therapy may mean the difference between life and death, and even more important the difference between comfort and seemingly endless days of urinary agony.

Abnormal masses associated with the genito-urinary tract should immediately arouse suspicion. We think of the child with the large flank or abdominal mass of sudden appearance that is found to be a fatal Wilms' tumor of the kidney. We remember the man whose history tells us of testicular trauma following which the testicle did not regress and later the supposed epididymitis was found to be a cancerous testicle in which the trauma acted only to attract the patient's attention to the mass and was not of etiological significance; the elderly man with induration in the bulbous urethra associated with urinary difficulty and a stricture that dilated easily only to promptly recur and bleed, a certain sign of urethral cancer. There is the young woman with an indefinitely palpable mass in her upper left abdominal quadrant who in her youth had experienced repeated attacks of malaria. Too late, the enlarged spleen was found to be a widely metastasizing kidney tumor. Hence, any mass irrespective of its benign connotation in the region of the genito-urinary organs demands a positive diagnosis.

Recurrent bladder infections or persistent pus in the urine are indications that demand a complete urological study. In this way early instances of tuberculosis may be demonstrated when surgery and streptomycin may effect a cure. Chronic pyelonephritis may be found before irreparable damage is accomplished. With our newer antibiotics these patients can be given an expectancy of life heretofore thought impossible. The patient's gain depends entirely upon early diagnosis and accurate therapy. Progressive asymptomatic hydronephrosis often can be diagnosed only by pyelography following a persistent but minimal pyuria (microscopic). Recurrent attacks of gastrointestinal disturbances in the presence of normal gastrointestinal x-rays should be investigated pyelographically for it is

not unusual that upper urinary tract disease simulates stomach or intestinal disturbances. Plastic surgery on the renal pelvis or ureter for obstructive uropathies not only may be life saving, but may permit the individual to lead a life of economic independence as opposed to a variable degree of invalidism.

It would seem from our discussion thus far that there is little left for the practitioner in the treatment of urological patients. This is far from true because the patients we have discussed constitute only an extremely small portion of those with urological disorders.

Among the more common urological conditions requiring office treatment, probably the most important and largest group of urological patients are those suffering with prostatitis. Prostatitis is either inherently inflammatory or obstructive in its symptomatic stages and in every instance prostatitis is originally inflammatory. The treatment of acute prostatitis with fever is large doses of penicillin. Penicillin has almost entirely eradicated the need of prostaticotomy (incision and drainage of the prostatic abscess). Massage of the prostate in acute stages of prostatitis is to be avoided, but after the process begins to subside gentle massage is beneficial, but never oftener than every 5 to 7 days. As the patient improves and the prostate becomes less tender the massage may become more vigorous, but not to the point of creating pain. Prostatic drainage is the objective, not brutality.

Prostatic massage is a simple procedure and should be executed in order to force the prostatic fluid into the posterior urethra. A certain pattern must be followed. The seminal vesicle is first emptied with gentle downward pressure, then the upper portion of the prostate on the same side, the midportion and finally the apex of the gland. The opposite seminal vesicle and contiguous portions of the prostate are similarly emptied. The final stroke is down the mid-line or prostatic sulcus to empty the ejaculatory ducts and the posterior urethra so that the prostatic and seminal vesicle fluid is forced into the bulbous portion of the urethra and now can be brought to the urethral meatus by pressure on the bulb of the urethra.

Massage of the prostate is to be continued until the prostatic fluid consistently shows less than 10 pus cells per oil immersion field and as

this objective is reached the interval between massage is increased. The necessary duration of treatment is variable, ranging from a few weeks to many months. Failure to completely establish prostatic drainage, which is indicated by the reduced number of pus cells, is the most common cause for chronic recalcitrant prostatitis.

Second only to prostatitis is chronic urethritis in the female and this is to be expected because of the similarity embryologically. The treatment of this condition is even more trying than prostatitis and often the results of treatment leave much to be desired. The symptoms are urinary frequency, urgency, strangury and a bearing down sensation in the region of the vesical neck or vagina.

The urine, as obtained by catheter, is normal and the patient should be made aware of this for often these individuals fear they have some dreaded kidney disease or malignancy. The caliber of the urethra should be estimated and if the urethra does not permit a 28 F. sound to pass easily the urethra should be dilated so that it will accept without resistance a 28 F. sound. The bladder capacity should then be measured (normal 350-500 cc.). If the patient's bladder capacity is reduced she should have the benefit of a thorough urological survey.

If the urinary tract is found normal the urethra is to be dilated at weekly intervals and the use of an antispasmodic is often helpful. Tincture of belladonna (gtts x to xx q.i.d.) is often effective in reducing bladder spasm. Unquestionably the most important single therapeutic agent is the instillation of complete reassurance in the mind of the patient.

If the urethra is found to be abnormal or the vesical neck to be contracted some operative interference by endoscopic means will be necessary. However, reassurance, urethral dilatation and antispasmodics are still an essential part of the treatment.

Not long ago the small urethral caruncle found at the external urinary meatus of the female was accused of many shameful misdeeds. We have come to realize that this vascular protuberance is not as rare as was originally assumed and that most are asymptomatic and become symptomatic only when the patient accidentally discovers its presence and is both horrified and convinced that the lesion is a deadly cancer.



Most of these vascular extrusions are actually little more than a portion of redundant urethral mucosa and are insensitive. I am sure that most of them could be left alone if you could convince the patient of their unimportance; however, since an occasional such lesion is neoplastic they should be biopsied. This can be done easily as an office procedure. The base of the protruding tissue is infiltrated with procaine and most of the tissue snipped off. The base is thoroughly cauterized using the small hyfercating unit found in most physicians' offices.

In closing, I will discuss cystitis briefly. Cystitis is seldom a disease, but most frequently a symptom of upper urinary tract invasion by infection, either primary or secondary to some other condition. The patient, of any age group, who has a recurrence of cystitis is in dire need of a complete urological study. Too often one finds a large staghorn calculus with a completely destroyed kidney in the patient who boasts of "having had cystitis for years," or a young boy or girl with one or both kidneys irreparably damaged because of some congenital ureteral or urethral deformity whose recurrent cystitis could always be alleviated by "one shot of penicillin". We also find the patient with far advanced tuberculosis whose only symptom, which had occurred time and time again, was "cystitis." Even chronic pyelonephritis or pyelitis is not without hazard. Patients with chronic pyelonephritis in which

the activity continues seldom live to the age of 50 years. Thus, every instance of recurrent cystitis must be regarded with profound respect and carefully observed.

The etiological bacterial agent in the vast majority of patients with acute pyelonephritis is *E. coli*. We prefer to give these patients either Aureomycin or Terramycin in doses of 50 mg. four times a day and after five days this is reduced to 50 mg. twice daily and so maintained for an additional week. This small dosage is therapeutically effective and is usually without gastrointestinal side effects. In conjunction with this antibiotic we use a sedative for symptomatic relief and if the responsible organism is sensitive the patient is usually vastly improved within 48 hours. If there is not great improvement within this period of time we institute further studies which include urine cultures and sensitivity tests so that the effective chemotherapeutic agent can be administered. We would prefer to undertake these cultural studies from the first, but such a routine is too expensive for the average patient and, too, the patient's chief interest is symptomatic relief rather than any scientific assay of his or her misfortune.

This is a grossly incomplete essay on present day urological practices. However, it is hoped that it does present a panoramic view in which the details may be supplied by more comprehensive articles on the specific subjects.

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## INDIANA HEART FOUNDATION

**E**ACH YEAR, in February, and especially on St. Valentine's Day, the Indiana Heart Foundation conducts its annual solicitation of funds. This is also the month in which the postgraduate seminar is held in conjunction with Indiana University School of Medicine. In anticipation of these events the Foundation is reporting on its community service program, and is announcing the details of its research program.

Research on diseases of the heart and circulatory system will be supported at Indiana University School of Medicine by grants totalling \$20,600. Study of plastic arterial grafts and surgical procedures for increasing coronary circulation will be undertaken by the Department of Surgery. Methods of determining pressure and oxygen content within the heart, cardiac catheterization, and uses of the artificial kidney in treating cardiac failure will be investigated by the Department of Medicine.

The Indiana Foundation, together with its parent organization the American Heart Foundation, and Purdue University is embarking on a five-year study to provide time and energy saving shortcuts for agricultural workers. This

will be the first research of this nature to be conducted in the United States. A five-year budget of \$130,000 has been provided.

Heart disease is an important factor in disability and fatality of farm workers. One reason for this is that they tend to retire at an older age than do non-farm workers. It is estimated that in 1952, 38.6% of agricultural workers were 65 years old or older. Other types of workers had only 17% in this age bracket. Certainly, knowledge of the energy requirements for this type of work, and a study of job simplification would be of great value to this group.

A mobile trailer laboratory will be utilized in the study. Norms for energy requirements, cardiac output and physiological values will be determined by examining farm workers on the job. Various essential farm operations will be studied in the same way. More economical work methods will be investigated.

These are all research projects of the most practical importance. The Indiana Heart Foundation is to be congratulated for its choice of fundamental and at the same time practical problems. It stands a good chance of getting the most out of each research dollar.

## PEPTIC ULCER: AN OBSOLETE TERM

SEMANTICS — bad semantics — can be lethal! The expression “peptic ulcer” has been fatal to some patients, and can be fatal to more if it is not abandoned.

There was a time when duodenal ulcers and stomach ulcers seemed to have enough in common to justify an expression which would include them both. “Peptic ulcer” served that purpose well enough in its day, but its day is past.

The expression “peptic ulcer” means “benign ulcerating lesion of the stomach or duodenum” —caused, according to Dorland’s American Illustrated Medical Dictionary, by the gastric juice. This is all right for the duodenum. It is not all right—as a clinical or roentgenographic diagnosis—for the stomach. There is always included an uncertain proportion, varying from 10 to 20 percent according to the criteria used for diagnosis, of cases of ulcerating gastric carcinoma

which cannot be identified as such until a surgical specimen is examined microscopically.

“Peptic ulcer” is therefore far too inclusive a term to be useful; it is, indeed, a dangerous term, since it seems to say more than it does. “What is a good treatment for peptic ulcer?” is as foolish a question as “What is good treatment for a skin ulcer?” Yet it is asked, and many a case of early and potentially curable gastric cancer goes on to an inoperable or incurable stage because the doctor is thinking in terms of “peptic ulcer.”

Semantics—the meaning of words—is the business of editors; and it should be the business of editors to scotch this dangerous and obsolete expression wherever they encounter it. “Peptic ulcer” should be taboo in medical publications. Its elimination might save some lives.

—Hawaii Medical Journal

## AMERICAN RED CROSS

“EVERYBODY in the Red Cross has discovered ‘one great truth’ of life and is practicing it. There is no satisfaction in life except as it is experienced through people. People constitute the one great important factor in all human existence, and it’s our relationship to those people that makes satisfactions for ourselves.

“And so by membership in the Red Cross, caring for the needs, the spiritual, the intellectual, and material needs of others, you are not only expressing by that act the greatest truth of all life but, I venture to say, you’re making a very great investment yourselves that will yield you some day

the greatest of dividends, if you have not already experienced them.”

*Dwight D. Eisenhower*

One among every four persons in the United States is a Red Cross member and 1 among every 94 is an active Red Cross volunteer. One among every 6 persons in the United States received last year some kind of Red Cross assistance or training.

Traditionally in March millions of citizens in every part of the country open their hearts and their purses to support the humanitarian services of the American Red Cross. This organization is a great fellowship of good will in which all citizens are welcome. When we join the Red Cross we identify ourselves with each individual act of mercy this great organization performs anywhere in the world.



## ON THE VALUE OF RECORDING CLINICAL OBSERVATIONS

OUR PREDECESSORS were better at original medical writing than are we of the present generation. In this age of speed and efficiency most practicing physicians may have lost the urge to record observations and deductions therefrom. Workers in the basic sciences and medical research publish such a great proportion of the articles in medical journals that proper emphasis on the importance of clinical observations is lost. This has had much to do with the popular misconception that medical practice now is primarily a science. Since the successful management of a patient depends most upon the physician's judgment and thoughtful consideration, not by any means predominantly upon laboratory findings, there should be a re-awakening to the importance of clinical writing and teaching.

Not all the worth of a medical article is in its benefit to the reader. The writing of a discourse—requiring making and recording of observations, reading of pertinent literature, and the thinking processes which are essential—leaves its mark on the future interest and philosophy of the author. Wouldn't it be refreshing to have our colleagues prepare really original contributions for the County Medical Society programs rather than give a dull and incomplete abstract of the subject as written in a textbook of medicine?

We cannot deprecate the fine advances which have come in such great abundance from scientific research. However, the physician must remain the judge and his patients the jury in deciding the worth of a new discovery. Most of us depend upon the men in large universities

and research centers for pronouncements on the value of this and that, but aren't we missing something as individual physicians if we, too, don't make ourselves heard on these subjects? What physician would not improve his abilities and interests by careful preparation of an article on some phase of his medical practice?

A well-known surgeon and medical educator once complained to the faculty council of a current dilemma—that physicians had much to say but didn't know how, whereas the English teachers knew well how to express themselves but didn't have much to say. The first half of the statement is more appreciated by physicians who try for the first time to write an article than the last part by the English teachers. There is, however, an important principle embodied, namely, that English composition in the premedical course is not just a routine academic requirement but a very important practical part of the medical curriculum.

Medical writing takes such painstaking effort in collecting data but even more persistence in perfecting the form in order that the end product be clear in its meaning, interesting to read, and free of unnecessary complexity. Editors feel justified these days in requiring well conceived and well written articles. Their high standards should not stifle free expression of opinion or individuality of style, but should inspire us of the profession to sincere efforts and high discrimination in our contributions to the literature. An article rejected should be a challenge to new efforts and thoughts. "*Writing maketh an exact man.*"—Francis Bacon.

C. G. Culbertson, M.D

# The President's Page

FELLOW MEMBERS OF I.S.M.A.:

WE HAD a very satisfactory meeting in January with the Committee on Medical Education and Hospitals, at which Dr. E. L. Crosby, Director, Joint Commission on Accreditation of Hospitals, and Dr. G. H. Leveroos of the Council on Medical Education and Hospitals of the American Medical Association were in attendance.

There have been a number of points in the new accreditation set-up which were controversial or not clear. I feel that if I record some of these points they may be of some interest. One of these points concerns consultation in the hospital. A quote from the Commission's latest Bulletin will clarify this.

"Except in emergency, consultation with a member of the Consulting or the Active medical staff shall be required in all major cases in which the patient is not a good risk, or in which the diagnosis is obscure, and in all first caesarean sections, sterilizations, curettages or other operations which may interrupt a known, suspected, or possible pregnancy."

A doctor can be active in one clinical department only and have privileges in other departments.

There are two methods of arriving at the required staff attendance.

1. Require 75 percent attendance at monthly staff meetings.
2. If the Hospital Staff elects he may attend 75 percent of the quarterly general staff meetings and 75 percent of the monthly departmental meetings. This would make 16 yearly meetings, compared to twelve in the first case.

Members of the General Practice group are privileged to work in any of the different clinical services of a given hospital, in accordance with their experience and training, on recommendation of the Credentials Committee of the hospital. Further, that they be responsible to the Chief of the Clinical Service involved.

At the meeting it was agreed to write the Joint Accreditation Commission petitioning that the General Practice group be allowed to set up a group and the work done in this department would be reviewed at their monthly meetings. This attendance to count as a departmental meeting.

*Wm Harry Howard M.D.*

# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

Last year the Indiana Auxiliary pledged its support to the American Medical Education Foundation. Other state auxiliaries also joined this national effort.

How to support it was the question. We soon realized that the Hoosier Doctors' Wives must find some worthwhile project in which all counties would participate.

Then the A.M.E.F. "In Memoriam" cards were introduced to be used by physicians, their wives and families at the time of death to replace the long overdone flower habit.

The cards read:

### TO HONOR THE MEMORY OF

-----  
The American Medical Education Foundation has received a gift

from -----

A.M.E.F. Uses Such  
Contributions to Further the  
Cause of Medical Education

Each county auxiliary has been furnished with a generous supply of these cards so they will be available at the time needed, and instructions given that all Memorial contributions (which are tax deductible) should be earmarked by the contributor for the medical school of his choice.

We have received many favorable reports from the lay public regarding these cards. We are realizing it creates good public relations when a busy physician or his wife takes time to

remember an old friend, relative or patient with such a worthwhile remembrance.

### WINS AUXILIARY SCHOLARSHIP

During the Health and Safety Conference held January 8, 1954 at Purdue University, Barbara Jean May of Brookston was presented the "Woman's Auxiliary to the Indiana State Medical Association 4-H Nursing Scholarship" by Mrs. W. Burleigh Matthew, state president. Official judges of Purdue University selected Miss May from a statewide group of 4-H applicants who had submitted their 4-H records and a theme on "Why I Would Like to Be a Nurse."

For many years individual County Medical Auxiliaries have sponsored and assisted girls in nurses' training, but for the last three consecutive years the State Auxiliary has awarded this 4-H Nursing Scholarship which represents the combined efforts of all the County Medical Auxiliaries in Indiana.

### MRS. MYERS DISTRICT SPEAKER

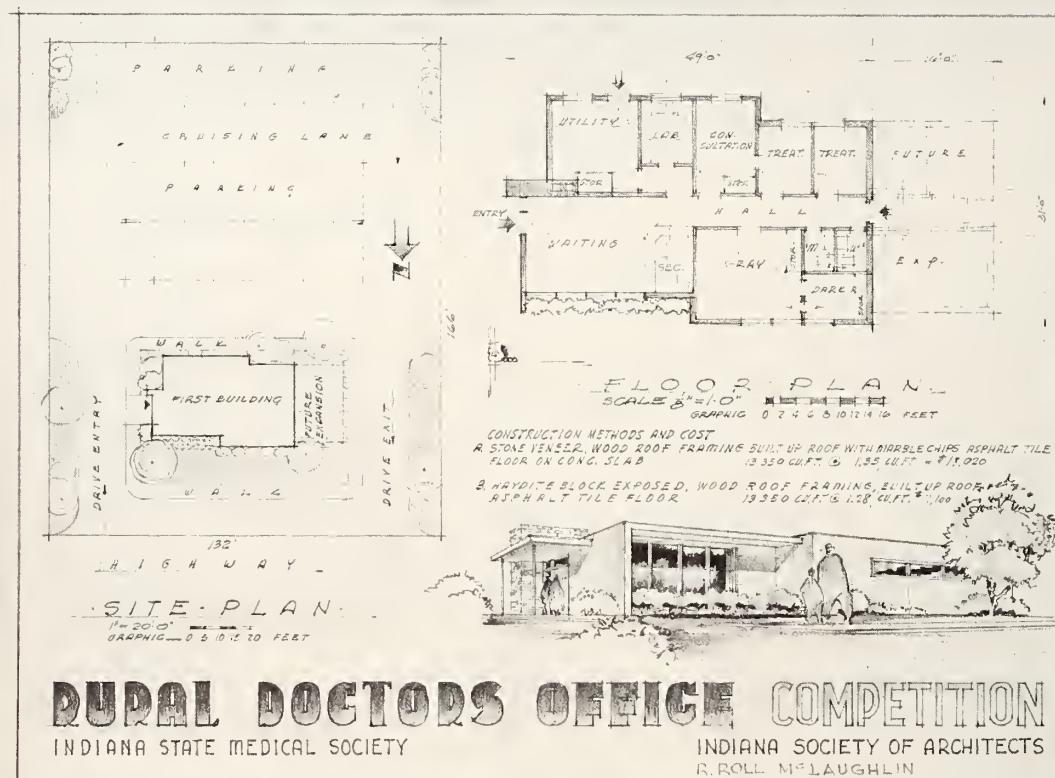
At the Thirteenth District Auxiliary meeting in Healthwin Hospital, South Bend, in November, Mrs. Roy V. Myers, state chairman of councilors, was the guest speaker. She discussed "Highlights of District Activities."

Registration for Auxiliary members was at noon preceding a 1 o'clock luncheon. Following a general business meeting, Auxiliary members played bridge and canasta before joining the doctors for the evening program in the Indiana Club.

Sue Matthew (Mrs. W. Burleigh)  
President, Woman's Auxiliary,  
Indiana State Medical Association



## EXCELLENT DESIGN FAILS TO PLACE ONLY BECAUSE OF INELIGIBILITY



**T**HIS DESIGN for a rural doctor's office, the last in a series, was originally placed second in the competition sponsored by the Indiana State Medical Association and the Indiana Society of Architects. It placed because of its compact arrangement and its reasonable separation of the secretarial office area from the waiting room. Unfortunately, it was found later that R. Roll McLaughlin, 122 East Michigan Street, Indianapolis, was not a registered architect, although working in collaboration with Edward James, A.I.A. That technicality ruled the design out of an award.

The consultation room was located properly in relationship to the treatment rooms. The utility room and laboratory, X-ray and dark room, however, were in two separate locations which was not considered to be the best setup.

Overall compact design would indicate a buildable and economical structure. The architect suggests two exterior finishes, one of stone veneer, the other Haydite block.

The site suggested provides ample parking space as well as room for proper expansion of the main building.

*To Ease A Burden***HEART FOUNDATION, AFFILIATES OFFER  
THREE-WAY EDUCATIONAL PROGRAM**

**T**HE INDIANA HEART FOUNDATION has expanded its community service program to include weight control classes, instruction in work simplification for cardiac housewives, and low sodium diet planning classes for heart patients.

The Foundation, in cooperation with the Indiana State Board of Health and the Home Extension Division of Purdue University, offers all programs without charge.

Each project has had the full endorsement of the county medical society wherever presented.

The Heart Foundation sponsored its first weight control program in Indianapolis last April. Following the success of this demonstration the sponsoring groups have conducted similar programs in Carroll, Clay, Dearborn, Howard, Miami, Montgomery, Ohio, Ripley and Wells counties.

Dr. B. L. Martz, Indianapolis, chairman of the Foundation's weight control committee, points out that "Weight control is, and must be, the overweight person's responsibility. The Heart Foundation can show those who enroll in the classes how to accept this responsibility and show them how to reach their objective—the shorter waistline—which should increase their lifeline.

"The time has arrived for an attack on obesity as a problem in public health. Weight control is a logical approach to the maintenance of health and the prevention of heart disease, diabetes and other diseases," Doctor Martz adds.

The Heart Foundation offers a series of five weekly classes. Each class lasts approximately two hours. State Board of Health or other dietitians serve as teachers and the Foundation also obtains physical education instructors to teach the weekly half-hour exercise periods.

Each enrollee must have a certificate signed by his physician before being accepted for the course.

The final class is taught by a physician who speaks on "The Rewards of Normal Weight". After the classes are concluded, periodic follow-up meetings are held to attempt to retain the participant's interest in losing excess poundage. To date more than 800 Hoosiers have enrolled in the classes.

Low sodium diet classes for heart patients or those who prepare meals for heart patients were first offered by the Foundation's Southwestern Indiana Heart chapter in Evansville, in cooperation with the county medical society. Here again, no patient or member of a patient's family is enrolled unless referred by the family physician.

**No Medical Discussion**

The classes are restricted to food preparation with no discussion of the medical situation involved. There are two classes; each lasts about one and one-half hours.

The third service program, work simplification for cardiac housewives is conducted to demonstrate the easier, quicker and more effective ways for performing tasks.

Women cardiac patients are referred to the classes by their physicians.

Teachers in these classes show the homemaker how to save as much as 75 percent of her walking, 75 percent of her movements and 60 percent of her reaching while performing her daily household tasks. Each course includes four two-hour lecture and demonstration classes.

No medical advice, treatment, diagnosis or examination is given in the classes. This service, like the other two outlined above, are adjunct to private practice and not competitive with it.

## INDIANA ACADEMY OF GENERAL PRACTICE ISSUES PROGRAM FOR SCIENTIFIC SESSION

**T**HE SIXTH ANNUAL SCIENTIFIC SESSION of the Indiana Academy of General Practice will be held in the Antlers Hotel, Indianapolis, on April 13, 14 and 15. The first day's schedule includes meetings of officers, directors, past presidents, and committee chairmen with the scientific program starting at 9 o'clock Wednesday morning, April 14. The program follows:

- 9:00-10:00 a.m. Leroy E. Burney, M.D.  
Director, Indiana State Board of Health  
"Indiana Health"
- 10:00-11:00 a.m. Burton A. Weisbren, M. D., Marquette University  
"Use of Modern Anti-Biotics"
- 11:30-12 Noon Clyde G. Culbertson, M.D., Indiana University  
"Newer Concepts of Viruses"
- 2:00- 3:00 p.m. E. Grey Dimond, M.D., University of Kansas  
"Practical Electrocardiography"
- 3:30- 4:30 p.m. Elmer Hess, M.D., Erie, Pennsylvania  
"The General Practitioner as a Urologist"
- 8:00 p.m. Annual Banquet (Ball Room)  
Phil Thorek, M.D., Chicago  
"Food for Thought"

### THURSDAY, APRIL 15

- 9:00-10:00 a.m. Lyman T. Meiks, M.D., Indiana University  
"Practical Aspects of Water Balance in Children"
- 10:00-11:00 a.m. Meyer Naide, M.D., Philadelphia  
"Diagnosis and Treatment of Peripheral Vascular Disease"
- 11:30-12 Noon H. B. Shumacker, M.D., Indiana University  
"Surgery of Peripheral-Vascular System"
- Noon-2 p.m. Luncheon  
Judge H. Dewitt Owen, Administrator, State Welfare Department, Speaker  
"Doctors and the State Welfare Program"
- 2:00- 3:00 p.m. "The Past President's Lecture"  
R. V. Platou, M.D., New Orleans  
"Management of Poliomyelitis"
- 3:30- 4:30 p.m. H. L. Smith, M.D., Rochester, Minnesota  
"Correlation of Heart Valves and Heart Sounds"
- 4:30- 5:00 p.m. J. O. Ritchey, M.D., Indiana University  
"Pancreatitis"
- 8:00 p.m. "FOUNDERS LECTURE"  
Joint Meeting with Indianapolis Medical Society  
Alfred C. Kinsey, Ph.D.  
Indiana University  
"Human Sex Behavior"



*"Men are never so likely to settle a question rightly as when they discuss it freely."*  
—Southey

## KOKOMO DOCTORS FORM GROUP FOR CONTINUING SELF-EDUCATION PROGRAM

SEVERAL KOKOMO PHYSICIANS met last November 10 to organize a Medical Study Group. The expressed purpose was to stimulate interest in a program of continuous self-education in scientific medical matters by means of meeting together periodically.

Their plan, already in operation, is fourfold. They will (1) discuss topics currently appearing in the medical literature, (2) organize scientific material reviewed, (3) correlate clinical experiences, and (4) present this information for informal discussion with the hope that all attending physicians may benefit by the knowledge offered.

Since the basic purpose of the meetings was defined as being exclusively scientific education, devoid of organized business, economics or politics, the Medical Study Group selected to maintain autonomy from the Howard County Medical Society and from the staff of the St. Joseph Memorial Hospital.

Any physician sincerely interested in the meetings and willing to contribute to the programs is invited to attend.

The fourth Tuesday of each month, throughout the year, was decided upon as the time for the meetings; the hour, 7:30 p.m.; the place, the

Physicians' Library, basement floor of St. Joseph Memorial Hospital, Kokomo.

The group determined, by drawing, the order of each physician's responsibility for presenting his paper or review. It was also decided that each month the physician in charge will notify the members as to the topic for discussion. Should it become impossible for the designated physician to present his paper on schedule, he personally will be responsible for making suitable substitution, thus ensuring a program.

The first regular meeting of the group was held on December 29. Thomas M. Conley, M.D., selected as his topic "Recent Trends of Thought in Clinical Obstetrics". Discussion by the entire group then centered around Doctor Conley's paper.

The January 26 schedule called for a paper on "Headaches" by Philip E. Prather, M.D.

Subsequent meeting dates and the physicians in charge are: February 23, George M. Jewell; March 23, T. J. Bruegge; April 27, Richard W. Halfast; May 25, Stanley M. Mendelson; June 22, Ernest C. Murray; July 27, William F. Tranter; August 24, John H. Alward; September 28, Max W. Rudicel; October 26, Marvin N. Golper; November 23, Elton R. Clarke, and December 28, Max M. Earl.

## A Letter of Interest:

The following letter was sent to Evansville hospitals by Dr. Paul D. Crimm, immediate past president of the Indiana State Medical Association:

### BOEHNE TUBERCULOSIS HOSPITAL

Evansville 12, Indiana

*Thoracic Surgery*  
*Bronchoscopy and Esophagoscopy*  
PAUL D. CRIMM, M.D. *Director*  
LOFTON H. HARRIS, M.D.

*Board of Directors*  
DON SCISM, *President*  
RICHARD E. MEIER, *Vice-President*  
CHAS. P. SCHNEIDER, M.D.  
C. C. HERZER, M.D.

December 30, 1953

To Whom It May Concern:

Practical nursing schools should be organized in all hospitals rather than have a school here and there. A proposal for a practical nursing school separate from each hospital will cost our community money which it either does not possess or money which could be saved. Each hospital can afford to manage a practical nursing school of their own; a school which should remain practical instead of theoretical. We can do this without much additional expense. We owe this to the public as a goodwill gesture for the money they donate to the hospitals.

Practical nurses could be paid a salary in proportion to the length of time they spend in training. This type of training with bedside teaching and occasional lectures might take three years. Many nurses aides will make good practical nurses if taught thru experience rather than by the didactic and demonstration method. Many women need to make a living while securing this education and cannot attend a 12 month's course, at the end of which they will own a diploma but will have acquired little "common horse sense" about nursing care. These comments propose a practical and economical approach to the "shortage of nurses" problem.

Respectfully submitted,

*Paul D. Crimm M.D.*

## INTRODUCING:

# Fort Wayne and Gary Physicians Become Members of THE JOURNAL Editorial Board

By action of the Council of the Indiana State Medical Association at the October 18 meeting in French Lick, George N. Lewis, M.D., Gary, and Samuel R. Mercer, M.D., Fort Wayne, were elected members of the Editorial Board of THE JOURNAL. Their appointments became effective January 1.

The new Editorial Board members, who will serve for three year periods, succeed Thomas M. Conley, M.D., Kokomo, and Clyde G. Culbertson, M.D., Indianapolis.

## —Doctor Lewis

Doctor Lewis is a native Chicagoan, graduate of the University of Chicago, and received his medical degree from Loyola in 1945. He interned at Cook County Hospital, Chicago, in 1945-46, then served two successive residencies there. In 1946-47 he was a resident in neurology and from



1948 to 1950 served a residency in internal medicine.

Doctor Lewis is certified by the American Board of Internal Medicine, is an associate in the American College of Physicians, a clinical instructor of neurology at Loyola and a clinical instructor of medicine at the Chicago Medical School.

Doctor Lewis has been married for five years and has two young sons. He has been in practice in Gary for two and one-half years; serves

as a deputy coroner in Lake County, and says his hobbies are reading and bridge.

## —and Doctor Mercer

Born in Pittsburgh but a "Hoosier by choice," Doctor Mercer completed his education in a conventional manner. Son of a Pittsburgh attorney who practiced there for 50 years, he went to Pittsburgh public schools, was graduated from Syracuse University, and then received his medical degree from the University of Pittsburgh School of Medicine. His internship was served at St. Francis' Hospital, Pittsburgh.



He'd thought while in training he would make a career of obstetrics. A duodenal ulcer thwarted those plans. So Sam Mercer went into the western Pennsylvania coal fields to do general practice among the miners and their families. Recurrent trouble with the ulcer convinced the young physician he should go into some field of medicine where he could maintain fairly regular hours.

A fellowship to the Mayo Clinic and a two year residency in dermatology gave him his answer. From Mayo's Doctor Mercer went to New York where he served a residency at the New York Skin and Cancer Hospital. Amply prepared but not quite certain how he wanted to apply his knowledge, Doctor Mercer went to sea for three years serving as ship's surgeon for a commercial steamship line.

Home again, he started to look for a location—a city of about 100,000 where there was an opening for a dermatologist. Through A.M.A. he became interested in Fort Wayne. He's been



there since 1938. His interests are as varied as his experience; he's an officer in the Presbyterian church, is in charge of the Fort Wayne City Clinic, has been a backyard farmer, and at all times is interested in traveling to new or favorite places. He has just returned from a southern cruise.

Doctor Mercer is married and has two daughters.

Professionally, he is certified by the American Board of Dermatology and Syphilology and is a member of the American College of Physicians.

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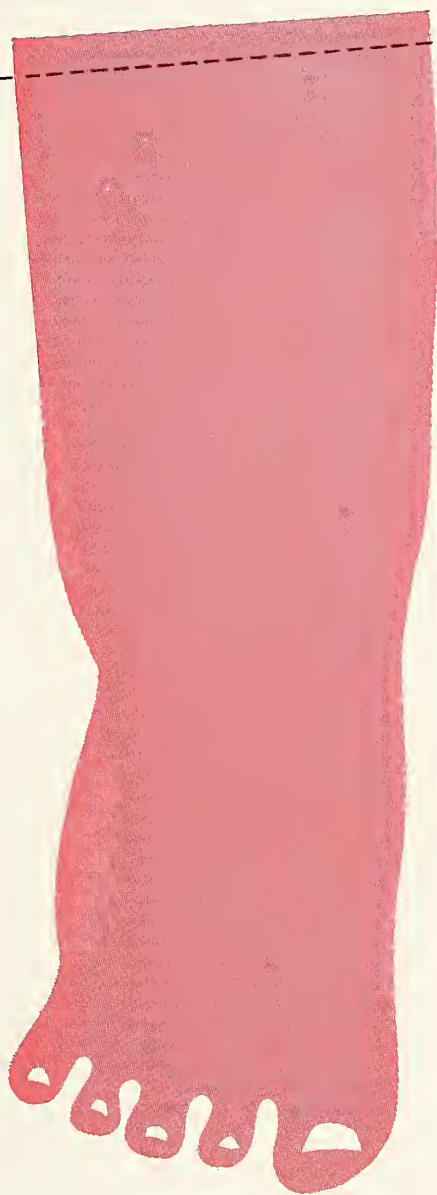
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\*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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**This is the second appearance of a new feature—  
a summary of Washington news—which will be  
airmailed from the capital on the ninth of each  
month.\***

## THE MONTH IN WASHINGTON

Washington, D. C.—Although the budget defense and farm policy are monopolizing Washington headlines, Congress is paying more than casual attention to the health and social security fields. In these, as in other legislative areas, it has for its guidance a specific program, laid down by President Eisenhower in his various messages during the first few weeks of the session. The question now is whether this closely-divided Congress will have the time and/or the inclination to follow through on everything the administration wants.

Before Congress settled down to its task, the President met with a group of American Medical Association leaders, who discussed with him the Association's position on several important pieces of legislation. Present at the White House meeting, in addition to Mr. Eisenhower and Sherman Adams, Assistant to the President, were AMA President Edward J. McCormick, Trustees' Chairman Dwight H. Murray, President-Elect Walter B. Martin, and Washington Office Director Frank E. Wilson.

Congress got into the health and welfare field with no waste of time. Within five days after Congress reconvened the House Interstate and Foreign Commerce Committee, under the chairmanship of Rep. Charles Wolverton (R., N. J.), began an exhaustive series of hearings on voluntary health insurance, further evidence that the Administration is determined to get some action in this direction.

Chairman Wolverton as long as four years ago was interested in legislation to help pre-paid insurance programs extend their coverage and in-

crease their benefits. In 1950 he incorporated his ideas in a bill, but it was not acted upon by the committee and was not revived until this year. Now the atmosphere is much more favorable for Mr. Wolverton's proposal. Not only is he chairman of the committee and his party in control of Congress, but his ideas have strong support from the administration.

Basically the Wolverton idea is an FDIC for voluntary health insurance. In about the same way the Federal Deposit Insurance Corporation insures bank deposits up to a certain limit, the Wolverton program would insure (or re-insure) various types of hospital, surgical, and medical insurance programs. The proposal is for the federal government to set up a national health insurance underwriting corporation. To keep the corporation going, the member plans would contribute a certain percentage of their gross receipts, possibly 2%.

With the national corporation underwriting unusual risks, the individual programs could offer catastrophic or "complete" coverage. By scaling individual premiums to the family income the member plans also could offer protection to families with very low incomes. The national corporation would pay possibly two-thirds of each subscriber's claim in excess of, say, \$500 or \$1,000 in any one year.

Another piece of legislation, receiving favorable attention, also would help families with their medical expenses—a proposed liberalization of income tax deductions allowed for medical expenses. Under present law, only that part of medical expense exceeding 5% of taxable income may be deducted. The pending legislation would drop this to probably 3% and raise or eliminate the maximum limit. In past years scores of bills

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\* This is a service from the Washington office of the American Medical Association.



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Counterbalanced tube stand, providing adjustable focal-film distances up to 40 in.	YES	NO	NO	NO
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Automatic selection of large or small focal spot	YES	YES	NO	NO
45 x 78-in. or less space requirement	YES	NO	NO	NO

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pointed in this direction have been introduced. If this is incorporated in the general tax overhaul legislation, it is believed to have a good chance of enactment.

Secretary Hobby's Department of Health, Education and Welfare is firmly behind a proposal to have the federal government show more leadership in vocational rehabilitation of the handicapped. At this writing it is too early for any good indication as to whether physicians will be brought under social security. The administration's bill would blanket in most self-employed groups, including dentists, attorneys, architects and farmers, in addition to physicians. Rep. Carl Curtis (R., Neb.), chairman of the subcommittee which investigated social security, apparently feels the same way. However, a substantial number of the members of the House Ways and Means Committee, which must pass on the bill, are known to feel that compulsion should not be used on groups that do not want Old Age and Survivors Insurance.

From all indications available during the first few weeks of Congress, a showdown fight may be unavoidable on medical care for military dependents. Defense Department, with support from the President, wants dependent care extended and made uniform among the three services, with military physicians carrying as much of the responsibility as they can. Under the Defense Department plan, dependents who could not be taken care of at military installations would be allowed to obtain their care from private sources, with the government paying almost all of the cost.

The American Medical Association agrees with the Defense Department that all dependents should receive medical benefits as nearly uniform as possible. However, AMA contends that wherever possible dependents should use private physicians and private hospitals, and that the military personnel and facilities should be employed only where civilian facilities are inadequate.

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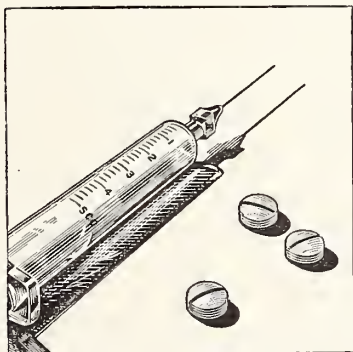
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# Deaths . . .

**Floyd T. Romberger, M.D.**, who served the Indiana State Medical Association as president in 1947, died on January 1 in Methodist Hospital, Indianapolis. He had been ill for six weeks.



Doctor Romberger, whose home was in West Lafayette, had been a practicing physician in Tippecanoe County for 33 years.

Born in 1887 in Elizabethville, Pennsylvania, Doctor Romberger was a graduate of the University of Pennsylvania School of Medicine. He received his degree in 1909. During World War I he served for 18 months as a captain in the Army Medical Corps and shortly after established his practice in Indiana. In 1926 Doctor Romberger first served the Indiana State Medical Association as a member of the Committee on Anesthesia. He was a diplomate of the American Board of Anesthesiology. From that year, he gave his services unselfishly, both professionally, and to the state association. From 1927 through 1929 he was chairman of the Committee on Postgraduate Study; he became Ninth District Councilor in 1930 and served through 1943; he was Chairman of the Council from 1940 through 1944 and until November, 1945; named president-elect, he was a member of the Executive Committee during 1946 and assumed the state presidency in 1947. Previously, he served in 1932 on the Committee on Scientific Work; in 1933-34 on the Editorial Board and again in that post from 1935 through 1939; in 1935 was chairman of the Section on Anesthesiology; from 1941 through 1947 was on the Committee on the Budget and served as chairman of that committee in 1948; from 1941 through 1947 he was a member of the Inter-Professional Health Council; in 1944-45 was on the Committee for the Study of Lay Activity in Medical Practice; in 1945-46 served on the Council on Medical Service and Public Relations; and in 1947 was an ex-officio member of the Committee on Scholarships.

Doctor Romberger was an honorary member of Tippecanoe County Medical Society, the state association, and American Medical Association. He was past master of West Lafayette Masonic lodge, a member of the Methodist church and the Scottish Rite.

Dr. Floyd T. Romberger, Jr., Indianapolis, is a son.

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**Percy R. Pierson, M.D.**, 65, New Albany physician for many years, died December 29 in St. Joseph Infirmary, Louisville. He had been ill for several months and hospitalized for three weeks.

Doctor Pierson was a native of Marengo. He received his medical degree from the University of Louisville School of Medicine in 1912. After serving his internship at City Hospital, St. Louis, he established practice in New Albany. During World War I he served as a lieutenant.

Doctor Pierson was a member of Floyd County Medical Society, the Indiana State and American Medical Associations, staffs of St. Edward's and Floyd County Memorial Hospitals, and had lodge, fraternal and banking affiliations.

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**Albert E. Stoler, M.D.**, 73, died December 16 in Parkview Memorial Hospital, Fort Wayne. He had been a practicing physician in Fort Wayne for 50 years. He received his degree in medicine in 1903 from the Fort Wayne College of Medicine. Doctor Stoler was medical examiner for several insurance companies, having served one company for 41 years.

In addition to his professional activities, Doctor Stoler was an ordained Melchizedek high priest of the Church of Latter Day Saints.

He was on the Parkview Hospital staff, a

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member of Allen County Medical Society, the Indiana State and American Medical Associations.

Wilbur F. Dunham, M.D., 71, Kempton, died January 7 from a coronary thrombosis shortly after meeting a group of friends in Frankfort.

A native of Tipton county, Doctor Dunham

was graduated from the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906. He practiced one year in Pickard then opened an office for the general practice of medicine in Kempton. He had practiced there since with the exception of 12 years when he was superintendent of the Indiana State School at Fort Wayne.

During World War I Doctor Dunham served in the medical corps.

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## NEWS NOTES — from State and Nation

The Foundation of the American Society of Plastic and Reconstructive Surgery has announced scholarship regulations for the fifth annual contest sponsored by that group.

Deadline for manuscripts is July 1, 1954. Essays should be about 5,000 words in length, on a subject which is the result of some original research, either clinical or experimental, in the field of plastic or reconstructive surgery. There are Junior and Senior classifications and two main prizes are offered, each consisting of a three-months plastic surgery scholarship with full maintenance in a number of selected leading services in the United States and abroad.

For further information, write to the Award Committee, in care of Jacques W. Maliniac, M.D., Chairman, 30 Central Park South, New York, New York.

**The Thirteenth Annual Essay Contest** of the Mississippi Valley Medical Society in 1954, has been announced by Harold Swanberg, M.D., Secretary. A cash prize of \$100, a gold medal and a certificate of award will be given for the best unpublished essay on any subject of medical interest, including economics and education, and of practical value to the general practitioner. Certificates will also be granted physicians entering essays rated in second and third place. The winner will be invited to present his essay before the annual meeting of the Mississippi Valley Medical Society in Chicago September 23-24. Entries must be received by May 1 and contestants must be members of American Medical Association. Address inquiries to Dr. Swanberg, 209-224 W.C.U. Building, Quincy, Illinois.

### Proctologists to Meet In Chicago April 8-11

The Sixth Annual Convention of the International Academy of Proctology will be held in the Palmer House, Chicago, April 8, 9, 10 and 11. All meetings during the convention are open to all physicians. There is no fee for attendance.

Because general practitioners, as well as gastroenterologists and proctologists, face proctologic problems in their daily practice, much of the program has been planned to answer their questions, the Executive Office announcement says. Full details may be obtained from the Executive Office of the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

### Dr. K. G. Kohlstaedt Heads Lilly Division



Kenneth G. Kohlstaedt, M.D., professor of medicine at Indiana University School of Medicine, has been named director of the Clinical Research Division of Eli Lilly and Company. A new division, its personnel is made up of

clinicians and technical personnel on the staff of the Lilly Laboratory for Clinical Research at Indianapolis General Hospital.

Doctor Kohlstaedt is an Indianapolis native and received his degree in medicine in 1932 from I. U. He has had a long association with General Hospital, where he interned, served as assistant superintendent and medical director. He has been with Lilly's since 1935, engaged in clinical research and specializing in problems of the heart, blood and circulatory system.

He is a member of many professional groups, a former president of the Indiana Heart Foundation and since 1948 secretary-treasurer of the Central Society for Clinical Research.

### I. U. Psychiatrist Named To National College Committee

Dr. Eldred F. Hardtke, clinical psychiatrist on the Bloomington campus of I. U., has been named as a member of the Committee on Mental Hygiene in College which is one of the sixteen conference committees which will report to the Fourth National Conference on Health in Colleges to be held in New York May 5-8. The Committee on Mental Hygiene in College is being headed by Dr. Lewis Barbato of the University of Denver. Dr. Hardtke was certified as a diplomate in psychiatry following the mid-December examinations of the American Board of Psychiatry and Neurology held at the New York Psychiatric Institute.

### Doctor Retires from General Practice Christmas Eve

Dr. Robert W. Reid, a physician in Union City for more than 40 years, selected Christmas Eve as the date of his retirement from the general practice of medicine. He plans to devote full time to his specialties, roentgenology and radiology, at the Union City Memorial Hospital. He was the first chief of staff at that hospital, and was roentgenologist at Randolph County Hospital in Winchester for 25 years.

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### Woman Physician Renamed City Health Officer

Dr. Berniece M. Williams, 3526 North Washington Road, Fort Wayne, has been reappointed for a four-year term on the City Board of Health. She is the first woman to serve on the board and her full term appointment came six months after she was named to fill out the unexpired term of Dr. M. B. Catlett whose death created the vacancy.

Dr. Williams is the wife of Dr. A. H. Williams of the Duemling Clinic, Fort Wayne. She practiced in New Haven and during World War II was physician for the Fort Wayne city schools. She retired from active practice in 1945 when her husband completed a tour of duty with the navy.

Dr. Thomas James, Jr., has been named Huntington county health officer and Dr. Richard W. Wagner, county physician for 1954 by

the Huntington county commissioners. Doctor Wagner, a former serviceman, recently located in Huntington and was recommended for the post by the Huntington County Medical Society.

### Greenfield Physician to Become Medical Missionary

Dr. Wilbur Beeson, a 1951 graduate of Indiana University School of Medicine and former pastor of the Friends church in Greenfield, will leave with his family between March 15 and April 1 for Kenya Colony, British East Africa, where he will serve for the next five years as a medical missionary. Doctor Beeson has been in private practice in Greenfield with Dr. R. E. Kinnaman and Dr. Ted Kirby for the last eight months. His medical training and experience has been planned with such service as his objective. Mrs. Beeson is a registered nurse. She is a graduate of Ball Memorial Hospital School of Nursing.

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## Symposium on Venereal Disease Scheduled for April

The Sixth Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held in the auditorium of the Department of Health, Education, and Welfare, Washington, D. C., on April 29 and 30, 1954, it was announced today by Dr. James K. Shafer, Chief of the Public Health Service's Division of Venereal Disease.

The sessions are open to all physicians and

workers in allied professions who are interested in participating. These symposia usually draw hundreds from all parts of the country and are the occasion for exchange of the latest available information by some of the outstanding authorities in the field of venereal disease.

The topics that will be discussed at this symposium will cover many aspects of venereal disease control including basic and clinical research, serology, epidemiology, treatment, program operation, and professional education.

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Dr. Charles E. Geckler, Muncie pathologist, has been admitted to the attending staff of Ball Memorial Hospital following action by the board of directors at a recent meeting.

Dr. Willard T. Barnhart, Evansville urologist, has been named president of the Deaconess Hospital staff in Evansville. Other new officers are Dr. Dallas Fickas, vice-president; Dr. Joseph W. Begley, secretary-treasurer; Dr. C. W. Cullnane and Dr. James H. Crawford, members of the executive committee, and Dr. R. Case Hammond, chairman of the liaison committee.

Officers of the medical staff of St. Joseph Hospital, South Bend, for the coming year are Dr. Richard A. Ganser, president; Dr. A. R. Templeton, vice-president; Dr. Charles F. Martin, Jr., secretary and Dr. H. C. Wurster, treasurer. The staff election was held January 6.

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## Hoosier Doctors Active In Other Organizations

Dr. John W. Bretz, Huntingburg, who has been active for a number of years in Kiwanis club, has assumed the presidency of the Huntingburg club.

Dr. Harold Nelson, who recently returned to Rushville after 14 months service in Korea, told members of Rushville Rotary club recently of his experiences with an army mobile hospital, emphasizing the value of the use of helicopters in transporting wounded men and the great need for blood. Doctor Nelson was with Ball Memorial Hospital, Muncie, before going into service.

Dr. H. F. Bonifield who left Warren several months ago, after practicing medicine there for 19 years, returned recently and while in Warren talked to the Kiwanis club there telling of his experiences as health officer for a three-county area in Florida. He is now located in Inverness, Florida.

Dr. A. N. Ferguson, Fort Wayne physician, was guest speaker at the December meeting of

the Anthony Wayne Chapter of the Indiana Society of Professional Engineers in the Hotel Van Orman, Fort Wayne.

Dr. Benjamin Grant, native of Muncie and now a practicing physician in Gary, was the principal speaker at the homecoming services held prior to the holidays in the Bethel AME church in Muncie. Doctor Grant, a pre-medical student at Ball State College, received his medical degree from Howard University, Washington, D. C. A surgeon, he is on the staffs of Methodist and St. Mary's Hospitals, Gary.

Dr. Louis W. Spolyar, director, Division of Industrial Hygiene, Indiana State Board of Health, and assistant professor of industrial medicine at Indiana University School of Medicine, was one of the speakers at a Conference on Silicosis sponsored by the McIntyre Research Foundation February 1-3 in the King Edward Hotel, Toronto, Canada. Doctor Spolyar spoke on "Practical Aspects of Silicosis Control" on February 1 and served as session chairman for the morning meeting February 2.

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### Pledges to Ball Hospital Building Fund \$2,627,882

Collections had passed the \$240,000 mark in early December, a report on the hospital expansion building fund for Ball Memorial hospital showed. Pledges to the fund at that time were \$2,627,882.

Final plans for the new wing were to be discussed at the annual meeting January 23.

New staff appointments at Indianapolis General Hospital include **Dr. Richard W. Dyke**, medical director, and **Dr. Adrian Freed**, Attica, who will become resident physician in obstetrics and gynecology on July 1. Doctor Dyke began his duties in mid-December.

**Dr. C. G. Herzer**, Evansville, is the new president of Boehne Hospital board. He had been a member of the board for several years. Doctor Herzer is in the general practice of medicine in Evansville.

**Dr. Charles P. A. Zervas**, who recently completed a 2-year tour of duty with the U. S. Navy, has resumed the general practice of medicine at 2605 Shelby Street, Indianapolis. His wife, **Dr. Phyllis K. Zervas**, is also in practice at that address. Doctor Zervas, a lieutenant, served for one year aboard the U. S. S. Essex off Korea.

**Dr. John D. Ralston**, who has been in practice in Indianapolis, has opened an office in Portland in the Weiler building. Doctor Ralston, who received his medical degree from Indiana University in 1932, is a native of Redkey. For a number of years he was in the clinical research department of Parke, Davis & Company, Detroit. He has practiced in Indianapolis since 1944 with the exception of three years spent in Colorado Springs.

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### Several Counties Name 1954 Health Officers

Cass County commissioners recently named Dr. Charles A. Ballard, Logansport, as county health officer for a four year period. Doctor Ballard had served in the post for one year.

Dr. Charles E. Austin, who recently returned to Anderson after serving for a year with an army medical unit in Korea, has been named Madison county health officer. His term began January 1.

Three Grant county physicians were shifted in their posts when county commissioners met recently. Dr. George R. Daniels, who recently resigned as county coroner, was appointed county health officer for a four year term. Dr. Henry Alderfer was appointed coroner to fill the unexpired term of Doctor Daniels. Dr. P. L. Sthair was named county home physician for one year, replacing Dr. A. D. Burge, who had held the post for several years. All three appointees are practicing physicians in Marion.

Dr. William B. Sigmund, Columbus, has been named health officer by Bartholomew county commissioners. He will serve a four year term.

Noble county commissioners renamed Dr. J. R. Nash, Albion, county health officer for a four year period.

**Dr. Lofton H. Harris**, who has been associated with Boehne Hospital at Evansville since April, 1953, has been certified as a specialist in chest surgery by the American Board of Surgery. A graduate of the Medical College of Virginia, Doctor Harris served four years as a major with the Army Medical Corps, went into general practice on his return for a year and then went to the Medical College of Virginia for five years postgraduate work in chest surgery before becoming associated with Dr. Paul D. Crimm, Boehne superintendent and outstanding chest surgeon.



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**Dr. I. L. Faith**, who has practiced in Newburgh since 1949, has been recalled to military duty. He has been ordered to report to Camp LeJeune, North Carolina, where he will be attached to the Marine Corps. **Dr. Arthur Rogers**, who was recently discharged from military service, will take over Doctor Faith's practice. Doctor Rogers is a graduate of Loyola University's School of Medicine.

**Dr. Harold R. Griffith**, 1946 graduate of Indiana University School of Medicine and formerly a resident of Vevay, has been certified by the American Board of Radiologists after completing postgraduate work at I. U. Effective January 1 he became chief of radiology at the Veterans' Hospital, Indianapolis, and instructor at Indiana University Medical Center.

### **South Bend Hospital Drive Passes Halfway Mark**

Because he has seen hospital needs outstrip developments in the 52 years since he established his practice in South Bend, Dr. Stanley A. Clark, veteran physician, has given a personal gift of \$50,000 to the St. Joseph County Hospital Development drive. His contribution has boosted the fund to \$325,000. The goal is \$625,000.

Doctor Clark, now retired although still active as secretary-treasurer of the South Bend Medical Foundation, brought the first X-ray equipment to South Bend in 1901. He was one of the founders of the South Bend Medical Foundation and has served on the board of directors of Healthwin Hospital since its opening in 1911.

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### **Vanderburgh Medical-Civic Dinner to Feature Othman**

The 100 guests from among Evansville leaders in industry, business, the professions, religion, education and labor will hear Frederick C. Othman, Scripps-Howard columnist, at the annual Medical-Civic dinner February 18. The event is scheduled for the Hotel McCurdy.

Mr. Othman will speak on "Confusion on the Potomac" which he will develop in the light vein which has made him read nationally.

The annual Medical-Civic dinner is one of several affairs planned by Vanderburgh county physicians each year in the furtherance of their active public relations program.

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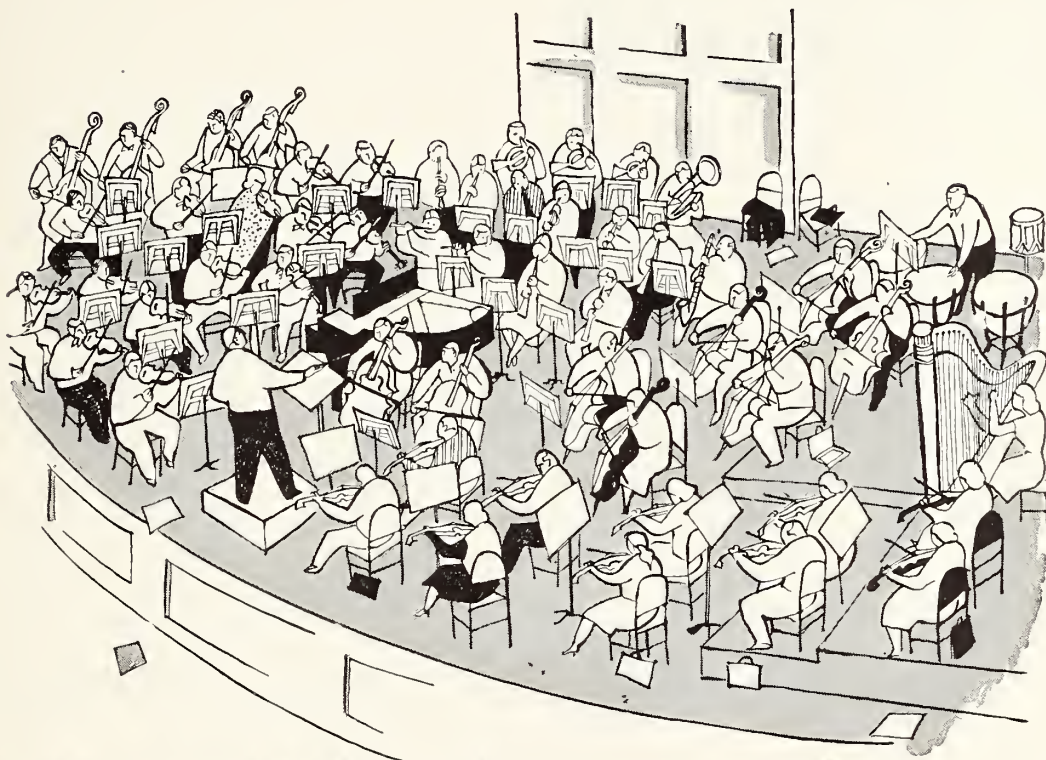
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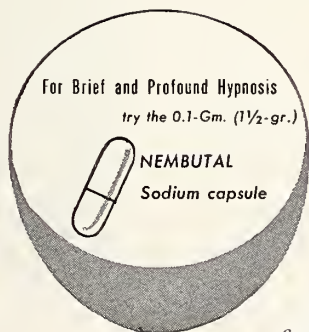
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## Waldron Physician Retires After 62 Years Practice

James E Keeling, M.D., Shelby county's oldest practicing physician, retired in January after completing 62 years service to several generations of Shelby county residents. Following his graduation from the Medical College of Indiana in 1891 he settled in Waldron where he will continue to reside.

In reporting his retirement the Shelbyville News made Doctor Keeling the subject of a column "Personalities Worth Mentioning". After recounting some of his "horse and buggy day" experiences the article concluded:

"Many things have changed in the past 62 years for Dr. J. E. Keeling of Waldron, but one thing remains the same—a sick person is still a person in need of his help."

Doctor Keeling is the father of Col. Forest E. Keeling, now with a U. S. Army Hospital in Germany, and a former physician in Portland.

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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

December 13, 1953

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Wm. Harry Howard, M.D.; W. L. Portteus, M.D.; Roy V. Myers, M.D.

Albert Stump and Robert Hollowell, attorneys; J. A. Waggener, executive secretary; Robert J. Amick and Kenneth W. Bush, field secretaries.

Statements of receipts and expenditures and report on the budget for November for the Association and THE JOURNAL were approved.

### Membership Report

Number of members December 11, 1953 . . . 3,808\*  
Number of members December 11, 1952 . . . 3,750  
Gain over last year . . . . . 58  
Number of members December 31, 1952 . . . 3,787

\* Includes 145 in military service (gratis)  
123 \$10.00 members (residents and interns)  
251 senior members  
76 members, dues remitted by Council  
2 honorary members

Number who have paid AMA dues:

1951 . . . 2,997; 1952 . . . 3,569; 1953 . . . 3,604\*\*

\*\* 420 members who were permanently exempted in 1952 are included in above figure.

### Headquarters Office

On motion of Drs. Howard and Myers the Executive Committee is to recommend to the Council that the chairman of the Executive Committee be authorized to sign Association checks in lieu of the chairman of the Council when the chairman of the Council is not available for this purpose.

Mr. Amick, field secretary, reported on his activities.

Mr. Bush, field secretary, covered his activities for the past month and explained that he had appeared before two conferences of medical assistants to discuss public relations, as directed by the Executive Committee at its last meeting.

### Legislative Matters:

#### National:

The secretary reported on reports from several of the component county societies in which they

stated they had had or were planning a meeting with their congressmen regarding the Jenkins-Keogh bill and other legislative matters of interest to the profession.

### 1954 Annual Convention, Murat Temple, Indianapolis

*Speakers' honorariums.* The committee reconsidered its previous action of November 15, 1953, regarding the honorarium fee for out-of-state speakers, and on motion of Drs. Howard and Portteus, the committee rescinded its former action and agreed to pay a \$50.00 honorarium to out-of-state speakers in 1954.

The secretary reported on quotations from the Ad Company of Cleveland, Ohio, Twiet's Display Company of Indianapolis, and Griffith Display Company of Louisville, Kentucky, for the installation of booths at the 1954 meeting. This matter was left open for final decision at the next meeting.

*Scientific exhibits.* The committee discussed whether or not the scientific exhibit shall be expanded and the secretary called attention to the increased cost if the scientific exhibits were increased in number. Upon motion of Drs. Portteus and Howard it was voted that the scientific exhibit should be continued and the committee urged that the number of exhibits be increased.

### Organization Matters

Dr. Howard reported on the meeting held in St. Louis on November 30, 1953, between the delegates from Indiana and representatives of the Joint Commission on Accreditation of Hospitals and of the Council on Medical Education and Hospitals of the AMA, telling of the action of the Indiana delegates in introducing a resolution which was adopted by the AMA House of Delegates. The resolution calls for the Joint Commission to use every available means to publicize and clarify the regulations. It calls specifically for the use of the official journals of medical organizations.

Upon motion of Dr. Howard, adopted by consent, the committee agreed to try and procure Dr. George W. Crane as a speaker for the annual meeting of the Sunshine groups.

The secretary read the evaluation report of the Medical Exhibitors Association regarding the 1953 meeting which indicated that 47 exhibitors reported the convention "Good", 12 "Fair", and 4 "Poor", as far as exhibit participation was concerned.

A letter from the Kansas State Medical Society calling a meeting of the 14-State Conference in Kansas City on Sunday, January 10, was read and by consent Dr. J. William Wright, Sr., was to be

asked to attend and if he was unable to attend, Dr. Cleon A. Nafe was to be asked to go.

Request from the Indiana Heart Foundation for approval of the Indiana State Medical Association of their kit of materials on weight control and the approval of the letter from the Heart Foundation to the physicians of Indiana was reviewed by the committee and by consent approval was granted for use of the name of the association as a cooperating agency.

Resolution from the staff of St. Catherine's Hospital of East Chicago was read to the committee and by consent this resolution was to be referred to the Council.

A proposal for the association to consider investment of its funds in toll road revenue bonds was presented and turned down by consent.

Dues for the executive secretary in the American Public Health Association in the amount of \$15.00 was approved by consent.

### The Journal

*Report on advertising* was accepted by consent:

Total, 1953	\$28,507.49
Total, 1952	26,562.94

Net gain in 1953 \$ 1,944.55

Request of Dr. M. A. Austin concerning running biographical sketches of 50-year men was reviewed and referred to the Council on motion of Drs. Howard and Portteus.

### New Business

Request of the Michigan State Medical Society for naming one day of their annual Clinical Institute as "Indiana Day" was approved by consent.

Dr. Howard discussed the proposed conference of presidents and executive secretaries of the neighboring states and by consent the selection of a time was left up to Dr. Howard and the secretary.

### Future Meetings

Meeting of Medical Education Foundation, Chicago, January 24, 1954. It was taken by consent that a member of the Committee on Medical Education and Hospitals should attend this meeting, the selection of the representative to be made by Dr. Denny, chairman.

50th Annual Congress on Medical Education and Licensure, Chicago, February 8 and 9, 1954. By consent Dr. James W. Denny, Dr. Raymond J. Modjeski, and the executive secretary are to attend this meeting.

AMA annual session, San Francisco, June 21 to 25, 1954. Upon motion of Drs. Clauser and Portteus, the secretary was instructed to arrange for a headquarters suite in San Francisco for the AMA meeting.

There being no further business the committee adjourned to meet again at 5:30 p. m. Saturday, January 23, 1954, in the conference room at the Union Building, Indiana University School of Medicine campus, Indianapolis.



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# News from the County Societies

**Benton County Medical Society** members met December 17 in the Fowler Country Club. Following the dinner, an election of officers was held.

"Office Diagnosis of Common Ano-rectal Conditions" was the title of a tape recording of a telephone seminar presented to members of **Cass County Medical Society** at a dinner meeting in Memorial Hospital, Logansport, December 21. Dr. James M. McIntyre and Dr. Paul K. Cullen, Indianapolis, gave the discussion.

At the business meeting following the program, election of 1954 officers was held; the suitability of the present emergency call list was discussed; and the society pledged cooperation with the Indiana Heart Foundation on its weight control program.

Twenty-five members and wives attended the dinner.

A film on "Cancer" was shown to 10 members of **DeKalb County Medical Society** at their November meeting in Souder's Hospital, Auburn. Consideration of national legislation and amendments to the Social Security Act followed the annual election of officers. The next meeting was scheduled for January 12 in Sacred Heart Hospital, Garrett.

Dr. Stephen O. Schwartz, specialist at Cook County Hospital, Chicago, was the guest speaker of **Elkhart County Medical Society** January 7. He presented a paper on "Disorders of the Blood."

The meeting was held in the Hotel Elkhart with 80 physicians attending the dinner and meeting. Several guests from South Bend and Mishawaka were present. The next meeting was scheduled for February 4 in the Hotel Elkhart.

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"Blood Dyscrasias" was the title of the paper given by Dr. Earl H. Antes, Evansville, before members of the **Gibson County Medical Society** at the January 13 meeting. Doctor Antes then joined a panel discussion of his topic with Drs. Lindsay and Getty, also of Evansville, participating.

A business meeting followed and committees for 1954 were appointed.

Fifteen members attended the dinner and program in the Hotel Emerson, Princeton. The February 10 meeting was set for the same place.

---

Officers were elected and a scientific 3-D film on "Body Chemistry" shown at the Christmas meeting of **Hamilton County Medical Society**.

The county society and Riverview Hospital staff meetings were held simultaneously. A committee has been appointed to standardize the pharmaceutical requirements of the hospital to prevent duplication in the medicine supplies. Essential needs of the hospital emergency room were also discussed.

---

**Hendricks County Medical Society** members met at noon January 12 in Danville for a luncheon meeting with Dr. B. S. Roth, Indianapolis, as guest speaker. Doctor Roth spoke on "Routine Pediatric Practices". Twelve members were present. The next meeting will be held in Danville, February 9.

---

Thirty-three members and two guests attended the January 5 dinner meeting of **Howard County Medical Society** in the Hotel Francis, Kokomo. Dr. Sprague Gardiner had been scheduled as the guest speaker but was unable to attend because of bad road conditions. A short business meeting was held and the next scheduled meeting set for February 2.

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An informal party preceded the annual dinner December 15 of the **Knox County Medical Society** in the Orchard room of the Grand Hotel in Vincennes. Twenty-two members were present.

At a business session following dinner election of officers was held. R. J. Amick, I.S.M.A. field

secretary, was present and answered a number of questions concerning association affairs.

The next meeting was scheduled for January 19 also in the Grand Hotel, Vincennes.

---

**Lawrence County Medical Society** members met at noon January 6 in Dunn Memorial Hospital, Bedford, for luncheon and a general discussion of proposed legislation. The 15 members present voted to inform members of Congress of their attitude in regard to proposed Social Security legislation and on the Jenkins-Keogh bills. Robert J. Amick, field representative of I.S.M.A., was present.

The February 3 meeting was scheduled for the same place.

---

The December 21 meeting of **Madison County Medical Society** was held at the Guide Lamp Division of General Motors Corporation in Anderson with George Jacoby, director of GMC personnel services, as the guest speaker. Mr. Jacoby talked on "Industrial Nursing."

Seventy members attended the dinner meeting and later elected officers for the coming year.

The January 18 meeting was to be held in the Anderson Country Club.

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"Carcinoma of the Lung" was discussed by Wayne Carson, M.D., Indianapolis, before members of the **Montgomery County Medical Society** December 17 at an evening meeting in Culver Union Hospital, Crawfordsville.

The 28 members who attended later elected officers; gave approval to the program of the Indiana Heart Foundation to present classes on work simplification for cardiac patients and on low sodium diet preparation; and also approved the establishment of a prenatal clinic to be conducted by the Public Health Nurse.

The January 21 meeting was also to be held in Culver Union Hospital.

---

Members of **Morgan County Medical Society** met in the Martinsville Sanitarium December 13 for a dinner meeting and business session. Eight doctors attended.

A report on the A.M.A. Clinical Conference in St. Louis was given by R. J. Amick, field

secretary, after which the election of 1954 officers was held. A general business discussion followed.

It was announced that the next meeting would also be held in the Martinsville Sanitarium, on January 17.

Sixteen members of the **Noble County Medical Society** met December 15 at which time they viewed a motion picture on the treatment of varicose veins and resecting of the rectum. An election of officers was held followed by a general discussion of medico-economic and political issues.

The first 1954 meeting of **Orange County Medical Society** was held January 5 in the French Lick Springs Hotel with eight members present.

H. Lester Reed, M.D., Louisville, was the guest speaker. He presented a paper on "Traumatic Head Injuries."

The February meeting was also scheduled for French Lick.

The election of county society and hospital staff officers for 1954 was held in the Vermillion County Hospital at Clinton when the **Parke-Vermillion County Medical Society** met on December 16. Ten members were present for the dinner and business meeting.

The next meeting was to be held January 20 in the hospital.

Dr. Edwin Dyar, Indianapolis, presented a paper on "Eye Problems Seen in General Practice" before 17 members of the **Putnam County Medical Society** on January 8. Doctor Dyar spoke following a dinner served in the DePauw Union building, Greencastle.

Announcement was made of the next meeting which was to be held February 12 in the Union Building at 6:30 p.m.

The **Posey County Medical Society** held its December meeting in New Harmony when they elected officers for the coming year; deferred action on a proposal to affiliate with the Vander-

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burgh County Medical Society and welcomed four new members into the society. The new doctors are Dr. Raymond L. Hirsch, Mt. Vernon; Dr. Carroll Boyle and Dr. Ivan Gailey, Poseyville; and Dr. Marvin Utley, now at Deaconess Hospital, Evansville.

---

Reports from committee chairmen who served during 1953 and the election of 1954 officers highlighted the December 8 meeting of **Tippecanoe County Medical Society**. Forty-four members and 5 guests were present. Special reports were given on the Medical Education Foundation and on the hospital accreditation situation.

Dr. Lowell Smith, the retiring president, gave a short address expressing his gratitude for cooperation given him during his year in office.

---

Dr. Harris B. Shumacker, Jr., head of the department of surgery at Indiana University School of Medicine, spoke on "Surgery for Mitral Stenosis" at the December meeting of **Vanderburgh County Medical Society**. The meeting was held in the Hotel McCurdy, Evansville.

The January 12 meeting of the society, also in Hotel McCurdy, featured a talk by Wallace E. Herrell, M.D., Lexington, Kentucky, on "Clinical Uses of Antibiotics." Doctor Herrell was formerly with the Mayo Foundation. He served as professor of medicine at the Mayo Foundation Graduate School of the University of Minnesota in 1952.

Dr. Wm. O. Denzer was installed as president and a general business meeting followed.

More than 100 members attended the late November meeting of the Vanderburgh society which was held in Boehne Hospital, Evansville, when Dr. Paul D. Crimm reported on the House of Delegates action at the I.S.M.A. convention and a general discussion of the A.M.A. Clinical conference was held.

---

Members of the **Carroll County Medical Society** met December 16 in the country home of Ralph Maggart where they were guests of

Dr. Eva N. Kennedy, Camden, at the annual Christmas party.

Doctors and their wives were entertained during the buffet style dinner by Patricia Maggart who played a program of organ music.

Following the dinner a business meeting was held at which officers were elected for 1954 and Paul Eagan, district representative for the Blue-Cross-Blue Shield plan, discussed the proceedings of the first meeting of the newly formed 11th District Blue Shield Advisory Committee.

Kenneth W. Bush, ISMA field secretary, spoke briefly on the AMA Clinical Conference at St. Louis and discussed legislation pertinent to the medical profession.

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The **Daviess-Martin County Medical Society** and the Daviess County Hospital staff held a joint meeting December 7 at noon in the hospital. Fourteen doctors attended. Election of officers and a general discussion during which it was decided that a delegation from the group was to meet with their Congressman to discuss probable legislation in the Congress. There was some discussion also concerning the need for short postgraduate or refresher courses for doctors in the state.

---

Thirty-five members of **Vigo County Medical Society** held a business meeting in St. Anthony's Hospital, Terre Haute, December 8, electing officers for 1954. They also voted a per capita assessment for the Medical Education Foundation. Members discussed legislative matters, available wire recordings and films with R. J. Amick, ISMA field secretary, who was a guest.

---

**Johnson County Medical Society** and Auxiliary members met December 9 in the Franklin Country Club for a dinner meeting with 50 present.

Separate evening meetings of the two groups were held. The society elected officers, discussed their call service via the Johnson County Hospi-



tal and the importance of activity to defeat the proposed extension of the Social Security Act to include professional groups.

Fourteen members of **Rush County Medical Society** met December 10 in the Rush County Hospital for a dinner meeting, election of officers, and discussion with the ISMA field secretary of a number of routine matters.

Following the business meeting they viewed the film "The Inner Ear".

**Jefferson-Switzerland County Medical Society** members discussed both local and national problems affecting the medical profession at the

meeting December 14 in the Barn cafe, Madison. Officers for the year were elected. Robert J. Amick, field secretary, spoke briefly.

Reports from the ISMA convention, the post-graduate courses at Chicago which several members had been attending, and the AMA meeting in St. Louis were given members of the **Dearborn-Ohio County Medical Society** at their dinner meeting in the Dearborn County Country club December 17.

Officers were elected by the 14 members present. R. J. Amick, field secretary for ISMA, was a guest and spoke briefly.

### SERVICES OF YOUR ASSOCIATION

The Headquarters office of Indiana State Medical Association can handle inquiries concerning individual members more accurately if you notify them of Board certifications with the request that the information be placed in your biographical file.

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# District Society Meetings

The Thirteenth District Medical Society held two scientific sessions, an election of officers for 1954, and heard presidents of their state and national medical associations speak at their annual district meeting November 18 in South Bend.

Dr. Kenneth L. Olson, South Bend, was reelected district councilor for a three year period; Dr. Otis R. Bowen, Bremen, was elected district president; Dr. Hugh Miller, Elkhart, named vice-president, and Dr. O. E. Wilson, Elkhart, reelected secretary. Dr. G. O. Larson, LaPorte, will serve as alternate councilor.

The 1954 annual meeting will be held at Norman Beatty Hospital, near LaPorte, on November 17.

Other action taken during the business meeting included approval of an invitation by the Blue Shield Plan to set up a medical advisory committee to adjust any claims requiring individual attention.

Speakers on the scientific programs included Drs. J. V. Cassady, Carl S. Culbertson and Thomas P. Potter, all of South Bend. They gave papers on the morning program.

At the afternoon session Dr. William J. Baker, professor of urology, Cook County Hospital, Chicago; Dr. Henry T. Ricketts, professor of medicine at the University of Chicago; and Dr. Claire L.

Straith of the Straith Clinic, Detroit, were the guest speakers.

Dr. Wm. Harry Howard, Hammond, president of the Indiana State Medical Association, spoke at the luncheon in the Hotel LaSalle before approximately 200 northern Indiana doctors. He discussed a wide range of medical society interests including the need for smooth operation of emergency call service for doctors, the need to be alerted against the lowering of educational standards which would permit chiropractors to obtain licenses with greater ease, the availability of many medical recordings through the state association headquarters, continued vigilance against socialized medicine and the fine response of Indiana physicians to hospital drives and to the Medical Education Foundation drive.

Dr. Edward J. McCormick, Toledo, president of the American Medical Association, was the dinner speaker at 7 p.m. in the Indiana Club, South Bend. In a forceful address he urged expulsion from the profession of any doctors guilty of malpractice, discussed the attempts of the federal government to get into the medical insurance business, the veterans' care problem and the need for more hospital facilities.



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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced, with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Only a limited number of illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication of THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 10th of the month preceding date of issue.

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The

# Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 47 — March 1954 — Number 3

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## ACUTE SPONTANEOUS VOLVULUS OF THE RIGHT COLON WITH GANGRENE

THOMAS C. MOORE, M.D.

*Muncie*

**V**OLVULUS OF THE RIGHT COLON is one of the rarest conditions producing symptoms of the acute surgical abdomen. It was described first by Rokitansky<sup>10</sup> in 1841. The majority of the estimated 300 reported cases have been described in the foreign literature. Donhauser and Atwell<sup>5</sup> reviewed the British and American literature in 1949 and found reports of 94 cases, to which they added 6 of their own.

For volvulus of the cecum and ascending colon to occur, these structures must be mobile with a relatively free mesocolon. The anatomic variations in right colonic fixation which might predispose to volvulus have been reviewed in detail by Wolfer, Beaton and Anson<sup>12</sup>. They found that a sufficient degree of mobility to produce torsion of some degree existed in 11 per cent of their routine necropsy cases. However, the factors initiating volvulus are poorly understood. Previous surgery has been the most frequent associated finding<sup>4,5,6</sup>. Pregnancy and labor

Doctor Moore is in private practice with his father, Will C. Moore, M.D., in Muncie, and spends part time at the Indiana University Medical Center, Department of Surgery. He is a 1945 graduate of Harvard Medical School, and is certified by the American Board of Surgery.

Doctor Moore recently completed a tour of active duty with the U. S. Navy, serving as a lieutenant in the Medical Corps of the U. S. Naval Reserve. The paper was written during that period and is from the Surgical Service, U. S. Naval Hospital, Great Lakes, Illinois.

and distal colonic obstruction have been encountered in some cases. In many patients no possible initiating factor can be traced.

Considerable variation has been reported in the duration and severity of symptoms. Sweet<sup>11</sup> in 1935 called attention to the occurrence of chronic volvulus of the right colon with vague and intermittent symptoms. However, more acute symptoms of abdominal pain and vomiting are found in the majority of cases, and gangrene may be expected in approximately 20 percent. The right colon

was gangrenous in 2 of the 12 cases reported by Dixon and Meyer<sup>4</sup>.

Eighty-three of the 100 cases reviewed by Donhauser and Atwell were treated by operation, and 60 percent of them recovered. Resection had been carried out in 14 cases with only 3 recoveries. Although the mortality has been reduced in recently reported series<sup>4,7,8,9,13</sup>, gangrenous right colonic volvulus remains a serious problem. Due to the high mortality associated with gangrene and the limited number of reported cases managed by resection and primary anastomosis, it has seemed desirable to report a case of acute spontaneous volvulus of the right colon with gangrene which was successfully managed by resection of the terminal ileum and right colon with primary oblique end-to-end anastomosis of the ileum to the transverse colon.

### Case Report

The patient, a 21 year old white Navy enlisted man, was admitted to the hospital on May 18, 1953, with a story of severe, crampy abdominal pain of 4 hours' duration. The pain began approximately one-half hour after the patient had awakened in the morning and, at its onset, was associated with vomiting. The cramps were agonizing and caused the patient to double up every 2 or 3 minutes. The pain was most severe in the right lower quadrant and was becoming progressively worse at the time of admission.

There was no history of previous operation, serious illness or injury. It was of interest that the patient had had 3 episodes of crampy abdominal pain aboard ship during the 12 months prior to admission. All 3 of the attacks were relieved by vomiting. He was unable to recall any other instances of abdominal discomfort.

On physical examination the oral temperature was 99.2° F., the pulse 90 and the blood pressure 120/80. The heart and lungs were normal. The positive findings were limited to the abdomen. There was marked right lower quadrant tenderness with considerable spasm and guarding. In addition, cough and rebound tenderness were referred to the right lower quadrant. There was no apparent distention and no masses were felt. The abdomen was relatively silent, only occasional peristaltic sounds being heard. There was some tenderness on the right on rectal examination.

The system review was negative except for the previous history of abdominal cramps. He



Figure 1. Preoperative flat roentgenogram of the abdomen.

had had no urinary complaints and had passed a normal appearing stool one hour after admission to the hospital. The white blood count was 9,700, with 70 percent neutrophils, 28 percent lymphocytes, and 2 percent band forms. The red blood count was 4.7 million and the hemoglobin 14 grams. The findings on urine examination were within normal limits. Flat, upright, and lateral decubitus roentgenograms of the abdomen were taken and reported as normal (Fig. 1).

Because of the persistence and intensification of symptoms and the presence of marked right lower quadrant tenderness, the patient was taken to the operating room. This was approximately 2 hours after admission and 5 hours after the onset of symptoms. Although there were several unusual features to this case, a tentative diagnosis of acute appendicitis was made. Shortly after the spinal anesthesia was given, a bulging of the abdominal wall was seen in the right lower quadrant. A muscle splitting McBurney incision was made in the right lower quadrant. When the peritoneum was exposed, a black mass was visualized immediately beneath it. A small



incision was made in the peritoneum and the black mass was identified as gangrenous large bowel. Since a major resection would most likely be necessary and would require greater exposure, the McBurney incision was quickly closed in layers with interrupted sutures of fine silk. General anesthesia was started and the peritoneal cavity was reopened by means of a middle right rectus muscle retracting incision. A strong fecal odor was noticed as soon as the peritoneal cavity was opened. A gangrenous volvulus of the cecum and ascending colon was found. The right colon was completely mobile with a well developed mesocolon. The cecum was massively distended and displaced into the pelvis. The cecum measured approximately 7 inches in diameter. Although no perforation in the right colon could be identified, it remained black and malodorous even following derotation and observation while packed with warm saline solution sponges. The volvulus was largely derotated within the peritoneal cavity prior to its deliverance onto the abdominal wall and the direction of the twist, clockwise or counterclockwise, was not clearly determined. Some of the trapped air in the right colon escaped into the more distal colon and into the ileum following derotation. The bulk of the right colon was non-viable and its resection was regarded as necessary. A primary anastomosis was decided upon rather than some form of exteriorization procedure. The ileum was divided obliquely between Kocher clamps to give a larger lumen with a longer mesenteric border and a shorter antimesenteric one. The site of ileal transection was approximately 14 inches from the ileocecal valve, through an area of normal appearing intestine. The vessels of the mesentery of the terminal ileum and the right mesocolon were divided and ligated and the transverse colon was sectioned near its middle. This permitted removal of the gangrenous areas of the terminal ileum and the right colon with adequate margins of safety (Fig. 2). An oblique end-to-end anastomosis was carried out between the ileum and transverse colon. The anastomosis was an open one, and a two-layer closure was used, continuous 000 chromic catgut for the inner layer and interrupted Halsted mattress sutures of 0000 silk for the outer one. The anastomosis was checked and the lumen was found to be quite adequate. The defect in the mesentery and the mesocolon was closed with a continuous catgut suture, as

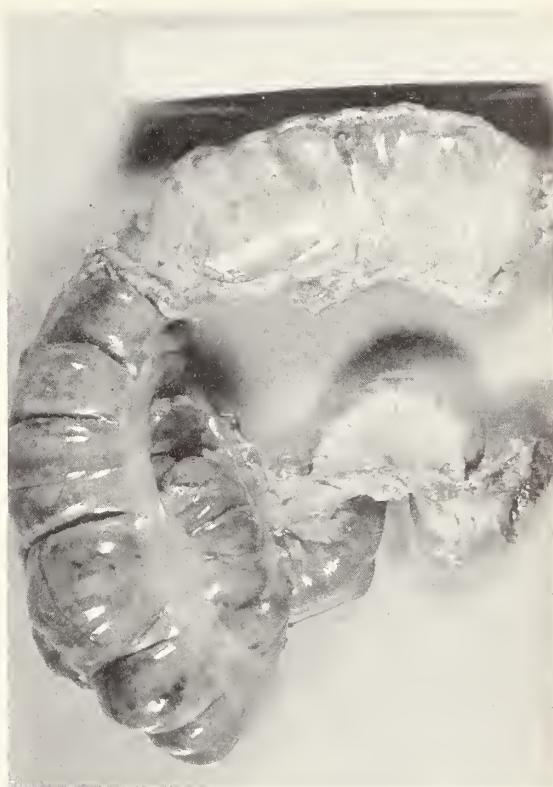


Figure 2. Photograph of terminal ileum and right colon removed at operation showing areas of gangrene.

was the peritoneum. The incision was closed in layers with interrupted sutures of fine silk. The patient tolerated the procedure well and was returned to the ward in good condition.

The postoperative course was essentially uneventful. Gastric suction and parenteral fluid and electrolyte replacement were employed. Parenteral terramycin and penicillin were given. Bowel sounds were first heard 24 hours following operation and continued to be present thereafter. The patient remained afebrile and the abdomen soft. The patient was ambulatory within 24 hours after operation. His first bowel movement occurred 6 days postoperatively, and the skin sutures were removed at 7 days. The wounds healed well and the patient was asymptomatic when he was discharged from the hospital as fit for duty on June 15, 1953.

### Discussion

The clinical course of the volvulus in this case was more fulminating and the degree of pain more severe than generally has been reported. Laparotomy was carried out 5 hours after the onset of symptoms, and the terminal

ileum and right colon were gangrenous. It is of interest that the physical, laboratory and roentgen findings were inconclusive both with respect to establishing the correct diagnosis and in indicating the degree of vascular impairment. There is some dispute in the literature concerning the diagnostic value of radiologic studies in cecal volvulus. Dixon and Meyer<sup>4</sup> stated that the diagnosis could not be made from the preoperative roentgenograms in any of their 9 cases in which these examinations were undertaken. However, McGraw, Kremen and Rigler<sup>7</sup> have described several roentgen features of cecal volvulus which may be helpful in making a preoperative diagnosis.

Although volvulus of the right colon has been said to occur more often in young men, the age distribution reported by Donhauser and Atwell<sup>5</sup> showed considerable variation. In the more recent series there has been a significant incidence in the older age groups and a number of the patients have been women<sup>1,2,6,7,9</sup>.

Laparotomy has generally been necessary to establish the diagnosis. The symptoms may be relieved by derotation in most cases in which gangrene is not a complication. However, the incidence of recurrence appears to be relatively high. It was a problem in 3 of the 12 patients of Dixon and Meyer. Various procedures have been suggested to fix the right colon and, thereby, reduce the likelihood of recurrence. The use of cecostomy or appendicostomy, both to fix the right colon and to achieve its decompression, has been suggested. Dixon and Meyer devised a procedure for securing the right colon by covering it with a large pedicle flap of peritoneum. Melchior<sup>8</sup> has recently advocated the routine utilization of right colectomy in all cases. However, colectomy in the absence of gangrene hardly appears indicated if some simpler procedure will suffice.

While most cases in which gangrene was discovered have been treated by an exteriorization type of resection, the availability of improved antibiotics, gastrointestinal suction and parenteral maintenance has increased substantially the safety of primary anastomosis. Resection of a gangrenous right colon for volvulus and primary anastomosis seldom have been employed. The remarkable success of Dennis<sup>3</sup> in carrying out resection for irreducible or gangrenous ileocolic intussusception, followed by primary anastomosis in 8 consecutive cases without mortality sug-

gested the applicability of resection and primary anastomosis for gangrenous volvulus of the right colon. If this procedure can be performed with minimal risk, it is clearly preferable to the exteriorization resection in selected cases.

### Summary

1. The literature concerning volvulus of the right colon is reviewed briefly.
2. A case of acute spontaneous volvulus of the right colon, with gangrene is reported. The patient was treated successfully by resection of the terminal ileum and right colon followed by primary oblique end-to-end anastomosis of the ileum to the transverse colon.
3. The suitability of resection and primary anastomosis for the management of selected cases of gangrenous volvulus is discussed.

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# PANCREATITIS\*

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WE HAVE RECENTLY REVIEWED 117 cases of pancreatitis from the files of three Indianapolis Hospitals—the Methodist, General and St. Vincent's. These cases were treated within the last five years and serve as the starting point for our investigation. Ivy and Gibbs<sup>21</sup> classify pancreatitis as follows:

1. Acute edematous or interstitial pancreatitis, with or without fat necrosis. (This should not be considered a lethal disease *per se*.)

2. Acute necrotizing nonhemorrhagic pancreatitis, with or without fat necrosis.

3. Acute necrotizing hemorrhagic pancreatitis, with or without fat necrosis.

4. Acute suppurative pancreatitis, with or without fat necrosis.

5. Chronic relapsing pancreatitis, which probably represents repeated sublethal attacks of the acute forms of the disease, and which finally produces the sixth type.

6. Chronic pancreatitis, fibrous, calculous, or calcified in type, or with two or more of these characteristics in combination. (Senile atrophy is associated with aging or arteriosclerosis of the blood vessels.)

7. Fibrocystic pancreatitis, which is a special form of chronic pancreatitis.

Here is the etiological classification of Gaster, Blain and Campbell<sup>17</sup>:

- I. Pancreatitis of infectious origin
  - A. Lymphogenous
  - B. Hematogenous
  - C. Extension via pancreatic ducts from duodenum or bile ducts
  - D. Direct extension from infective foci or diseased adjacent viscera
  - E. Activation of enzymes by bacteria in normal gland

- II. Pancreatitis of noninfectious origin
  - A. Due to reflux into pancreatic duct of
    1. Bile ("common channel" theory), incident to
      - (a) stone or edema of ampulla of Vater
      - (b) spasm of sphincter of Oddi
      - (c) miscellaneous factors
    2. Duodenal contents
  - B. Obstruction of pancreatic ducts by
    1. Epithelial metaplasia (Rich and Duff<sup>37</sup>)
    2. Stone in pancreatic duct or ampulla of Vater
    3. Tumor, stricture or edema.
    4. Duodenal diverticulum (Ogilvie<sup>29</sup>)
  - C. Trauma
  - D. Vascular accidents:
    - Embolus, thrombosis, rupture

## III. A combination of two or more factors.

Sanchez-Ubeda and Rousselat<sup>41</sup> discuss:

1. Acute pancreatitis—this designates the acute initial onset of the disease in a patient who had never had an attack before.
2. Chronic relapsing pancreatitis—This indi-

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cates the occurrence of more than one attack of the acute disease.

3. Subacute pancreatitis—this distinguishes between acute pancreatitis and chronic atrophic pancreatitis—represents phase of relapses and exacerbations.

4. Chronic pancreatitis—refers to late atrophic phase—calcification may or may not be present on x-ray—predominate signs are those of pancreatic deficiency with or without diabetes.

Cecil states that acute pancreatitis includes the hemorrhagic, suppurative and gangrenous types; that chronic pancreatitis is either interlobular or interacinar<sup>6</sup>.

Yater<sup>53</sup>, Berman<sup>2</sup>, Priestley<sup>33</sup> and Roberts<sup>39</sup> agree that there are three principle types of pancreatitis, viz., acute hemorrhagic (acute pancreatic necrosis); acute parenchymatous (acute interstitial pancreatitis and acute pancreatic edema are here included), and chronic pancreatitis. Because of its simplicity, we prefer to follow this classification (Table I.).

In summary, we may think of pancreatitis as we will as acute or chronic, infectious or non-infectious, but should remember, as H. Ogilvie<sup>29</sup> has said, that it varies from a condition characterized by the most agonizing abdominal pain imaginable, fecal vomiting, severe dehydration, and shock to "a bellyache with a raised diastase index in the urine." There is good reason to be-

by splanchnic nerve stimulation. Then, too, there is the interesting research of Farber<sup>14</sup> and Popper<sup>32</sup> wherein it is shown that pancreatic "changes" can be brought about by a low protein, high fat diet and that these changes can be reversed by methianine. Further, ethionine produces a loss of cytoplasmic basophilia of the pancreatic acinar cells but this can be prevented with methianine<sup>14</sup>. Thus nervous and metabolic factors might be considered.

A word about the "common channel theory." Gaster, Blain and Campbell<sup>17</sup> state that this condition has been said to exist in from 10 to 60% of the cases and (that) the figure of 60% is too high. Thus probably no more than 50% of the cases can be explained in this fashion.

It is logical to search for the element of obstruction in pancreatitis in the form of metaplasia in the pancreatic ducts, stone, stricture, etc., but obstruction in any of its forms is by no means a constant finding.

It is generally agreed that infection is not a cardinal etiological agent. Nevertheless, the presence of pathogenic bacteria, especially clostridia, may well be the deciding factor in the fatal cases<sup>24,31</sup>.

In conclusion, then, it appears that the most constant pathological occurrence in pancreatitis is a leakage of pancreatic enzymes (steapsin and trypsin) into the interstitial spaces<sup>21</sup>. This is surely the *sine qua non* of necrotizing pancreatitis if not Mr. Ogilvie's "bellyache with diastase in the urine" as well<sup>29</sup>.

#### CLASSIFICATION OF DISEASE IN THIS STUDY

TABLE I

Type of Disease	Number of cases
Acute hemorrhagic pancreatitis	33
Acute parenchymatous pancreatitis	48
Chronic pancreatitis and Relapsing pancreatitis	36
TOTAL NUMBER OF CASES	117

lieve that the different kinds of pancreatitis discussed are really only different stages of the same disease process even though these stages are not invariably successive<sup>32</sup>.

#### Etiology

An etiological classification has been given. We could embellish it by citing the paper of Mallet-Guy and Beaujeu<sup>28</sup> in which it is stated that pancreatitis can be produced experimentally

#### Symptoms, Signs and Diagnosis

The symptoms of acute pancreatitis are familiar to every physician. Pain in the upper abdomen associated with vomiting is the most constant complaint. In our review no significant seasonal correlation was discerned although many of the cases of pancreatitis occurring in December and January followed the festive holidays. In only 13 cases was alcoholism a definite contributing factor.

Twenty-four patients were reported as obese while only three were noted to be thin or emaciated. Fifty-eight patients were female; 59 were male. Table II describes the age incidence. It is seen that 82.2% of the patients were between the ages of 30 and 70 years and that 26.7% of all cases were between the ages of 50 and 60, the ages of the greatest incidence of the disease.

TABLE II

<i>Age Incidence</i>	<i>Number of Cases</i>
10-20	1
21-30	10
31-40	18
41-50	22
51-60	31
61-70	27
71-80	6
81-90	1

Seventy-two percent (72%) of all cases were admitted as emergencies. In Table III is found a tabulation of certain clinical features of interest. Not all the charts reviewed were complete and thus few of the total number of cases in any group total 117.

Further clinical features of pancreatitis in general are illustrated in Table III. In any case of pancreatitis large amounts of trypsin may find its way into the blood stream converting prothrombin to thrombin—concurrently blood vessel damage occurs. These events when associated with hypotension and hemoconcentration set the stage for thrombosis and infarction. Con-

tinued prothrombin conversion results in the exhaustion of prothrombin stores. As destruction of thrombin continues an increased clotting time develops and hemorrhage occurs<sup>23</sup>. This may be manifest as hematemesis, hematuria, uterine bleeding, cerebral or coronary thrombosis. We have found 18 cases illustrating this feature. Most patients are normotensive and either afebrile or slightly febrile on admission to the hospital. Anemia is unusual. The white blood cell count most commonly is between 6,000 and 20,000. A leukocytosis with a relative lymphopenia is infrequent in our series of cases<sup>39</sup>. Seventy percent (70%) of the cases we have reviewed have had less than 90% polymorphonuclear leucocytes. Albuminuria was found in 50% of our cases, glycosuria in approximately 25% and a combination of the two in 15%.

Yater<sup>53</sup> states that "chronic pancreatitis is almost always associated with cholecystitis and the symptoms of the two are practically identical." Others<sup>41</sup> feel that in this stage of the disease the signs and symptoms of pancreatic deficiency predominate. A case with steatorrhea and calculi seen in the pancreas on x-ray offers no particular diagnostic challenge.

TABLE III

<i>Clinical Feature</i>	<i>Number of Cases</i>
Coagulation disturbance	
Bleeding .....	12
Thrombosis .....	6
Blood pressure	
Hypertensive (above 150/100) .....	13
Non-hypertensive (below 150/100) .....	89
Temperature on admission	
98.6 or below .....	45
98.7—100.6 .....	46
100.7—102.6 .....	12
Over 102.6 .....	4
Hemoglobin	
12 grams per cent and above .....	95
Below 12 grams per cent .....	13
White blood cell count	
Below 10,000 .....	50
10,000—19,999 .....	43
20,000—29,999 .....	6
30,000—39,999 .....	2
40,000 and above .....	3
Analysis of numbers of polymorphonuclear leukocytes	
90% or over .....	30
Under 90% .....	72
Urine	
Albuminuria .....	50
Glycosuria .....	27
Albuminuria and Glycosuria .....	15

There has been much interest recently in the secretin test. This test is performed as follows:

The patient is required to fast for 12 hours. A blood specimen is drawn for diastase, then 100 milligrams of secretin and 15 milligrams of methylcholine are injected intravenously and intramuscularly respectively. Sixty minutes later blood is again drawn for diastase analysis. A difference in the diastase levels between the first and second samples of greater than 116 units (milligrams) is considered significant. It is necessary to have atropine sulfate gr. 1/150 ready for use against a methylcholine reaction. It is also cautioned that this test is contraindicated in chronic relapsing pancreatitis (a relapse may be initiated) and in asthma and coronary artery disease.<sup>41</sup>

The general range of blood diastase in the normal individual is from 80 to 150 units. Levels over 500 units are almost pathognomonic of pancreatitis although there are four other common conditions in which such levels may appear. These are renal retention (the diastase is not excreted), carcinoma of the head of the pancreas (obstruction to pancreatic ducts); perforation of duodenal ulcer (inflammatory obstruction) and salivary gland duct obstruction or adenitis (extra-pancreatic production of diastase)<sup>34</sup>.

Hyperglycemia with hyperlipemia (total cholesterol 780 to 1080) has been observed<sup>46</sup>.

In some cases of acute pancreatitis on x-ray examination of the abdomen an isolated loop of distended small bowel, simulating obstruction, is sometimes seen. Although not pathognomonic this is a helpful sign when present<sup>19</sup>.

Gray-Turners sign is a bluish yellow ecchymotic discoloration of the skin in the periumbilical and flank regions. It is said to usually appear around the third day of the illness and is said to be found in less than 10% of the cases<sup>39</sup>. Although certainly not specifically looked for, it is not noted in any of the cases in our series.

### Treatment

The prevailing opinion in this country is that the treatment of acute pancreatitis is medical and that surgery is to be reserved for the complications of the disease such as pseudocyst formation. In chronic atrophic pancreatitis surgery has little to offer as the gland has been destroyed and treatment must be channeled toward furnishing those substances it can no longer produce.

In the medical treatment of acute pancreatitis these things should be considered:

1. Relieve pain with the use of demerol or codeine but not morphine as this may cause spasm of the sphincter of Oddi or the pancreatic ducts.

2. Begin nasogastric suction and allow nothing by mouth. Thus both nervous and hormonal stimulation of the pancreatic secretion is lessened with a decrease in the leakage of enzymes into the pancreatic interstices. Ileus is prevented.

3. Correct any pathological alteration of blood volume, fluid, protein, or electrolyte balance. Calcium and potassium levels must be watched closely. It is noted that a calcium level of below 7 milligrams percent is said to be indicative of a fatal outcome and that the lowest calcium level is found on approximately the sixth day of the disease<sup>17</sup>.

4. Further reduce vagal nerve stimulation of pancreatic secretion by using atropine sulfate or banthine<sup>50</sup>.

5. Papaverine may be used in doses of 1½

grains every three or four hours to relax the sphincter of Oddi.

6. Sodium phenobarbital may be used intramuscularly for sedation.

7. Give aureomycin by mouth or other suitable antibiotic therapy. (It has been shown that lethal pancreatitis can be produced in dogs with the injection of 10 cc of bile into the pancreatic duct. If aureomycin is given by mouth the animals receive 100% protection. Intravenous aureomycin or penicillin give only 40% protection whereas prophylactic use of a polyvalent gas gangrene antitoxin protects in 60%. The most important microbes to be dealt with seem to be *clostridia*—normally found in liver, pancreas and intestine. Schweinburg and Fine believe it is the continued invasion of extra-enteral tissue by these organisms that causes the fatal outcome<sup>31</sup>. Similarly Dragstedt et al. have found that devitalized dog pancreas is highly toxic when allowed to autolyze within the peritoneal cavity but was not toxic after sterilized in the autoclave. *B. welchii* was found in 13 of 17 dogs<sup>12</sup>. Lewis and Wangenstein<sup>24</sup> found penicillin "G" effective in the treatment of this experimentally produced pancreatitis.)

8. Treat any pancreatic deficiency that develops.

9. Be alert to the possibility of spontaneous thrombosis, infarction or hemorrhage.

10. Novocaine has been advocated "not as a cure of the disease but for the correction of deviated reflexes and for attenuation of pain." The recommended dosage is 20 cc of a 1% solution injected intravenously at not more than the rate of 1 cc every 30 seconds. It may also be given as a continuous intravenous drip by dissolving 1 gram of procaine in 500 cc normal saline. The rate of administration should not exceed 40 to 50 drops per minute. Treatment is to be preceded by a test dose of 1 or 2 cc and may be repeated every three to four hours<sup>26</sup>.

11. Cortisone acetate has been employed in the dose of 100 milligrams per day given on three successive days. One case of necrotizing pancreatitis wherein it was used is reported and represents almost miraculous results. This therapy certainly merits further consideration<sup>48</sup>.

12. Yet in the domain of animal experimentation is the use of a soybean inhibitor of the pro-



teolytic action of trypsin (SBI). The serum of humans, dogs and other animals is known to contain an antiproteolytic agent which is active in suppressing the proteolytic effect of trypsin. This antiproteolytic factor is elevated in acute pancreatitis. Animals suffering from experimentally produced acute hemorrhagic pancreatitis have been brought out of shock and remarkably improved with the use of "SBI"<sup>40</sup>.

### Surgical Treatment of Recurrent Pancreatitis

In the surgical treatment of recurrent pancreatitis many procedures are advocated but the disease obstinately refuses to be completely or consistently amenable to any of them. We have adopted the following classification to facilitate discussion.

#### *Classification of Surgical Procedures Advocated in the Treatment of Recurrent Pancreatitis*

- I. Operations on the pancreas *per se*
  - A. Total pancreatectomy
  - B. Transplantation of duct of Wirsung
- II. Operations on the extrahepatic biliary system
  - A. Cholecystectomy
  - B. Cholecystostomy
  - C. Choledochostomy with or without transampullary T-tube drainage
  - D. Choledochojejunostomy en Roux "Y" or choledochoduodenostomy
  - E. Endocholedochosphincterotomy and sphincter dilatation
- III. Operations on the autonomic nervous system
  - A. Splanchnicectomy
  - B. Vagotomy
  - C. Sympathectomy
- IV. Subtotal gastrectomy (with vagotomy)

In the first group we find two operations neither of which is in wide use. Total pancreatectomy has been relegated almost exclusively to the realm of cancer surgery. Transplantation of the duct of Wirsung aims at removing obstruction to the flow of pancreatic juices and is a new procedure not yet well tested. For some peculiar reason the publication of scientific papers seems to be considered by many an urgent obligation stemming from considerations quite for-

eign to the varied fields of science. In particular we have reference to those completely negativistic efforts that are called forth by each new idea. In stating then that transplantation of the duct of Wirsung is a procedure needing further testing it must not be construed that we are condemning it—indeed we confess we know little about it.

In the second group of operations cholecystectomy is mentioned first. The surgeon confronted with recurrent pancreatitis coexistent with calculus cholecystitis performs cholecystectomy in the hope that he will eliminate the source of biliary tract infection. Note is made that biliary tract "infection and stones" are found in from 60 to 90% of the cases of pancreatitis<sup>4,26,39</sup>. The question of whether or not cholecystectomy will prevent further attacks of pancreatitis is met squarely by Probst and Sachar<sup>34</sup> in their well documented review of the subject. They report that in 65 patients who had acute pancreatitis 12 had cholecystectomy and in 2 of these recurrence of the pancreatic disease occurred. In 9 of these 65 patients cholecystectomy had been done before they were seen with their attack of pancreatitis. Thus in 11 of 65 patients cholecystectomy did not prevent further attacks of pancreatitis. In our series of cases there are 17 instances of pancreatitis ensuing in spite of previous cholecystectomy and 18 cases in which cholecystectomy has been done without recurrence of pancreatitis. In three cases cholecystostomy has been curative so far. It is logically concluded, then, that cholecystectomy must be done for the purpose of treating the gallbladder disease not the pancreatitis. (We are cautioned that the Graham-Cole test is unreliable in acute pancreatitis for the gallbladder may not visualize only to do so later when the attack has subsided.)

When the diagnosis of necrotizing pancreatitis is not made pre-operatively a diseased gallbladder is frequently discovered but inflammatory changes about the common and cystic duct may make cholecystectomy dangerous. Here then is the indication for cholecystostomy with tube drainage of the gallbladder. Should there be ampullary obstruction and a "common channel" in such a case, this procedure may accomplish decompression of the extra-hepatic biliary system as well as resolution of the cholecystitis.

Choledochostomy with or without transampullary T-tube drainage again presupposes the

necessity for biliary tract decompression and as has been seen would therefore be indicated in only 50% of the cases at most (the common channel cases.) It is possible, however, that a rubber catheter traversing the ampulla might cause compression of the pancreatic outflow tract even though it does effectually drain the common duct. A case of posthepatic obstructive jaundice treated with cholecystectomy and transampullary T-tube drainage resulting in a fatal, necrotizing pancreatitis is reported.<sup>47</sup> Moreover it is plainly undesirable to place a foreign body in an area already inflamed and, indeed, infected—especially when it is imperative that scarring be held to a minimum. Notwithstanding these objections choledochostomy with prolonged T-tube drainage (1 year) is strongly advocated by many authorities, among them J. T. Priestley.<sup>33</sup> (Note is made that the T-tube is clamped off for all but an hour twice or three times daily.)

Choledochojejunostomy en Roux Y or choledochoduodenostomy aim, again, at the diversion of bile away from the terminus of the pancreatic duct or ducts. The advocates of these procedures are enthusiastic.<sup>33, 4, 5</sup> When a common channel can be clearly demonstrated, when there is no pancreatic duct obstruction and when there is reflux of bile into the pancreatic ducts it would seem such side-tracking surgery would be useful. The difficulty of case selection is apparent. Moreover, the loss of neutralizing bile might result in duodenal peptic ulceration.

Endocholedochosphincterotomy and endocholedochal sphincter dilatation again presume the existence of a common channel. The case for the former is stronger than for the latter as one dilatation can hardly be expected to produce any permanent change. The formation of scar tissue with stricture (especially in the presence of infection) has been mentioned as a danger to sphincterotomy. If the sphincterotomy were patterned after the Ramstedt technique instead of being done through the mucous membrane this objection would be less forceful. In any event, sphincters cut elsewhere in the body more generally develop incompetence than stricture. The cardinal objection to sphincterotomy therefore, follows the same pattern of argument presented in the discussion of choledochojejunostomy.

Thus we come to our third class of procedures, those performed on the autonomic nervous sys-

tem. Formerly it was held that the sphincter of Oddi was relaxed by parasympathetic activity and stimulated to contraction by the sympathetics.<sup>10</sup> More recently it has been held that each system, sympathetic and parasympathetic, possesses constricting and dilating properties.<sup>3</sup>

Mallet-Guy states that the "vasomotricity" of the pancreas is said to be controlled by the splanchnic nerves whereas the sensory supply to the pancreas is "not ascertained."<sup>28</sup>

On the other hand, bilateral splanchnicectomy and lumbodorsal sympathectomy is said to afford complete relief of pain.<sup>9</sup> Ray and Neill<sup>35</sup> have shown that after removal of the left splanchnic nerves and the left sympathetic chain from T7 to L3 pressure on the head of the pancreas is experienced in the right hypochondrium. When the same procedure was carried out on the right side instead of the left, this pressure is felt in the left hypochondrium. The sensory supply is thus sympathetic and parasympathetic and to the head of the pancreas, at least, bilateral.

Cerebral cortical (psychogenic) stimuli act upon the pancreas through the vagus nerves causing ampullary and pancreatic duct spasm as well as enzymatic secretion. In response to emotional stimuli the stomach secretes an increased amount of hydrochloric acid which in turn produces pancreatic secretion. This reflex, too, is mediated by the vagus nerves.<sup>42</sup>

Mallet-Guy and Beaujeu<sup>28</sup> have recently reported 70 cases of "chronic relapsing pancreatitis" treated by splanchnicectomy. They claim excellent results in 83% of the cases and had but one death. Splanchnicectomy according to these authors "effects a vasomotor change which checks the development of inflammatory sclerosis and breaks the vicious reflex cycle responsible for acute or subacute recurrences."<sup>28</sup> Sympathectomy and splanchnicectomy are usually combined when this surgery is decided upon and it is usually sufficient to operate upon but one side. The selection of which side depends upon where the pain is most marked. The sympathetic chain from T7 to T12 and all three splanchnic nerves are divided. This may be conveniently done through the bed of the 10th rib transpleurally.<sup>20</sup>

Vagotomy used alone<sup>45, 43, 42</sup> or in combination with subtotal gastrectomy<sup>38</sup> has been advocated for the reduction of pancreatic secretions.

There is much to be said for these procedures. Some experimental work designed to study further the results obtained clinically have been re-



ported and is not altogether favorable.<sup>1</sup> It has been shown that if hydrochloric acid is secreted by the gastric remnant pancreatic juice will be forthcoming and that the pancreatic response to secretion is unchanged by partial gastrectomy. It would seem then that the efficacy of either vagotomy or vagotomy with subtotal gastrectomy must depend upon two factors both variable; viz., how much hydrochloric acid can still be secreted and how much is necessary to evoke the pancreatic response.

**Comparison of Medical and Surgical Mortality in Acute Hemorrhagic Pancreatitis**

It is currently felt by most authorities in this country that surgical intervention of any kind in hemorrhagic pancreatitis increases the mortality. Table IV shows our experience. The mortality in all cases of pancreatitis is approximately 1% ;

TABLE IV

*Surgical Mortality versus Non-surgical Mortality  
In Acute Hemorrhagic Pancreatitis*

	Number of Cases
Died with surgery -----	5
Recovered with surgery -----	16
Died with non-surgical management (Proved by autopsy) -----	10

in all cases of *proven* acute hemorrhagic pancreatitis it is 45%. Lichtenstein states that the operative mortality in this disease is 41.6%.<sup>49</sup> We, however, find it is only 24%.

We cannot state what the mortality in medically managed cases is because the diagnosis *cannot be made* without either surgery or autopsy. We can, however, state that there were only five deaths in the surgical group as compared with ten in the medical group. How many cases of hemorrhagic pancreatitis were treated medically and recovered *no one* can say. So, although we are not prepared to agree with Ogilvie<sup>29</sup> who states that "without surgery the mortality rate is 60% ; with it about 30%" neither can we agree with Lichtenstein's statement that simple laparotomy alone increases the mortality and that any additional surgical maneuver further increases it.<sup>49</sup>

When the diagnosis of hemorrhagic pancreatitis becomes a possibility in any given patient the surgeon need not fear exploration. His pa-

tient will fare far better than the case of gangrenous cholecystitis with an amylase of 250 units who is treated medically.

**SUMMARY**

1. 117 cases of pancreatitis were studied.
2. In acute hemorrhagic pancreatitis, twice as many deaths occurred in cases treated non-surgically as in those treated surgically.

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# ACUTE PNEUMOCHOLECYSTITIS

## A Case Report

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**A**CUTE PNEUMOCHOLECYSTITIS is an acute infection of the gallbladder characterized by the accumulation of gas within its wall and pericholecystic areas. In reviewing the literature only 25 cases have been reported. These cases have appeared almost entirely in the radiographic literature. This is the twenty-sixth case to be presented.

### Case Report

A 65-year old white male farmer was admitted to the hospital complaining of severe abdominal pain of three days' duration.

Past history revealed that he had had pneumonia at the age of 18, and typhoid fever at approximately the same age. Two years before the present episode he visited his local physician complaining of "bloating." He was treated medically and placed on a diet. There was no evidence of tarry or clay-colored stools. Jaundice was not seen.

Three days prior to admission, the patient developed severe abdominal pain which became

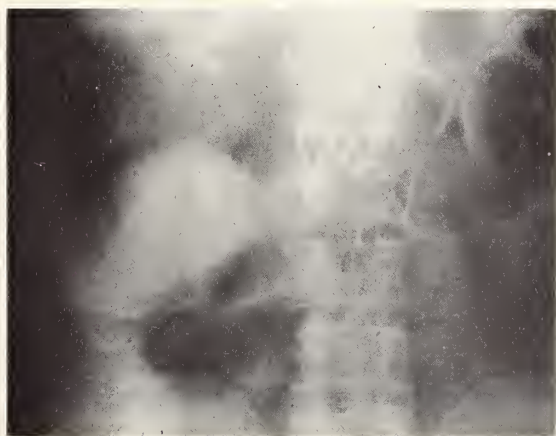
localized to the epigastrium and right upper quadrant. He felt that he was "tied up in knots." He did not vomit although nauseous, but was too sick to get about. He could not lie quietly in bed. The patient had not complained of such severe pain previously, nor had he experienced a similar attack in the past. He was seen by his local physician who made a diagnosis of a

localized to the epigastrium and right upper quadrant. He felt that he was "tied up in knots." He did not vomit although nauseous, but was too sick to get about. He could not lie quietly in bed. The patient had not complained of such severe pain previously, nor had he experienced a similar attack in the past. He was seen by his local physician who made a diagnosis of a

**Fig. 1a. Erect film: Fluid level is seen.**



**Fig. 1. Large gaseous shadow in the right upper quadrant in the region of the gallbladder. A dense concentric circle surrounds this shadow.**



ruptured viscus. A barium enema was done before admission to rule out a lesion of the colon. The patient was then sent to the hospital.

On admission, physical examination revealed a short, obese, white male who appeared acutely ill. Temperature was 101.6, pulse 96, respirations 24, and the blood pressure was 124/70. There was a slight splinting of his right chest with deep breathing. The lungs were clear to percussion and auscultation. The heart sounds were of normal sinus rhythm. The abdomen showed a marked rigidity and tenderness in the right upper quadrant and epigastrium. A definite mass was palpated in this area. The remainder of the abdomen showed a moderate spasticity, but no other masses were palpated. Emergency roentgenograms were made in the supine and erect positions to rule out a ruptured viscus (Fig. 1 & 1a). These revealed evidence of retained barium from the enema given before admission. In the right upper quadrant there was a fairly large gaseous shadow in the region of the gallbladder. There was a dense concentric circle surrounding this shadow. In the erect position a fluid level was seen. Air was not seen under either diaphragm.

Laboratory examination done the day of admission revealed: WBC 14,900 with 81% neutrophils, and 19% lymphocytes; RBC: 4.4 million, 13 grams of hemoglobin. Urinalysis showed a specific gravity of 1.025 and a 2+ albumin; otherwise the examination was negative. Subsequent urines were entirely negative.

Other laboratory examinations showed: Kahn-negative; NPN-31mg.%; urobilinogen-normal; cephalin-flocculation-2+ in 24 hours; bromsulphalein retention 11% in 30 minutes. Icteric index done several days after admission was 10. A serum bilirubin was reported as within normal limits. White blood counts were made on several occasions ranging between 11,000 to 26,300. Polymorphonuclear cells were 65% to 81% of the total count during this period.

The patient, acutely ill when admitted, was treated with parenteral fluids and antibiotics. He seemed to improve during the first few days. His temperature remained elevated for several days before returning to normal. Leukocytosis continued, though his acute symptoms subsided.

A cholecystogram was made approximately 10 days after admission. There was no evidence of a dye-filled gallbladder. In the location of the



Fig. 2. "Bubbly" shadow in the right upper quadrant. Interpreted as gas within the wall of the gallbladder.

gallbladder and the previously large gas shadow, an irregular shadow, bubbly in nature, was visible (Fig. 2). This was interpreted as gas within the walls of the gallbladder. A barium enema revealed no evidence of a fistulous tract (Fig. 3). An upper gastrointestinal series was not done.

Because of slight jaundice and the gaseous shadow in the right upper quadrant, exploratory laparotomy was advised. On opening the abdomen, the omentum was adherent to the gallbladder. The gallbladder was firm, indurated, and tense. The omentum was gently separated from the gallbladder until about one-half way down, a small abscess was accidentally ruptured. This was aspirated by suction and a culture taken. Because of this abscess and the acutely inflamed, indurated appearance of the gallbladder, a decision to do a cholecystostomy was made. The fundus was opened. It contained a considerable amount of thick, black bile. The mucosa of the gallbladder was markedly necrotic. It was aspirated carefully and a mushroom catheter was inserted and anchored. Culture of the fluid aspirated from the gallbladder revealed no growth for anaerobic bacteria after 14 days. Culture of





Fig. 3. Barium enema rules out fistulous tract from colon. "Bubbly" appearing shadow still present in right upper quadrant.

drainage from surgical incision revealed hemolytic staphylococcus aureus.

The patient ran a febrile course after surgery. On the fifth postoperative day, a collection of purulent material was drained from operative wound. Then the patient made good progress until day of discharge. Cholangiography was done to rule out evidence of calculi within the common bile duct (Fig. 4). This was interpreted as a negative cholangiogram. The cholecystostomy tube was removed. The wound continued to drain, however. The patient was given leave to return at a later date for an elective cholecystectomy.

During the next several weeks, the patient had considerable drainage from the cholecystostomy wound. He was readmitted to the hospital in November, 1951. The superficial wound was reopened and numerous silk sutures were removed. He was again given medical leave.

In January 1952, he reentered the hospital for an elective cholecystectomy. There were several



Fig. 4. Normal retrograde cholangiogram. Pancreatic duct outlined.

small draining sinuses in the right upper quadrant. Laboratory findings at this time were: WBC-10,750 with a normal differential, RBC-5.8 million, Hgb-16 grams, NPN-32 mg.%, serum bilirubin-.4mg.%, urine-negative. Surgery was done on January 10, 1952. On opening the abdomen there were multiple, but fairly easily separable adhesions about the gallbladder. There was a thick fibrous cord along the sinus tract extending from the skin to the top of the gallbladder. The gallbladder was freed and removed.

Report of the gross specimen was as follows: The gallbladder was small and contracted, having lost its usual appearance. It measured 5.0 x 1.0 x 1.0 cm. The wall cut with increased resistance. It was markedly fibrotic having a grayish-white appearance. The lumen of the organ was markedly compressed, being represented by a slit-like structure lined by greenish tissue. The wall averaged 4mm. in thickness. The normal structure of the gallbladder had completely disappeared.

Postoperatively, the patient did well. At time of discharge, the wound had healed completely.

## Discussion

It is a rare occurrence when, in an acute attack of cholecystitis, gas is found in the lumen of the gallbladder on roentgenographic examination. Rocco, Hunt, and Savran<sup>7</sup> and Quist<sup>6</sup> have tabulated the cases and reviewed the literature. It is interesting to note that 17 of the published cases have appeared within the past 10 years. Twenty-two cases have been diagnosed preoperatively since 1931. The relatively few cases that have appeared in the literature may be due to the rarity of the disease or to the lack of radiographic examination in the early phase of acute cholecystitis. It may be assumed that many more patients may have had this condition. Friedman, Aurelius, and Rigler<sup>3</sup>; Schmidt<sup>8</sup>; Culver and Kline<sup>1</sup>; Stevenson<sup>9</sup>; McCorkle and Fong<sup>5</sup> have shown that several recovered on medical treatment alone. Serial roentgen examinations proved this fact.

The roentgen findings are typical and pathognomonic for a diagnosis of emphysematous cholecystitis. McCorkle and Fong<sup>5</sup> demonstrated that in the first few hours no gas may be seen. Later the entire lumen of the gallbladder is distended by gas. A fluid level may be seen in the erect position at this stage (Fig. 1a). In this case, the symptoms were present for at least 72 hours. The lumen of the gallbladder is surrounded by a concentric ring of gas and still contains gas. The concentric ring may be seen faintly on the initial roentgenogram (Fig. 1). Later in the course of the disease, this shadow becomes mottled and bubbly in appearance (Figs. 2 and 3). In this stage, bubbles of gas found at a short distance from the lumen or the wall of the gallbladder may be interpreted as gas in the pericholecystic areas. The patient may recover with complete disappearance of the gaseous shadow.

## Summary

1. Another case of acute pneumocholecystitis is added to the literature.
2. Typical roentgenograms are seen: a gas-filled gallbladder, a concentric dense ring surrounding the lumen, a "bubbly" shadow indicating gas in the gallbladder wall. An incidental finding is that of a fluid level. No gas is seen in the biliary ducts.
3. This condition can always be diagnosed by radiographs.

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# SOME UNUSUAL CASES OF ARTHROPOD INFESTATION\*

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## Introduction

OUR PARASITOLOGY LABORATORY has been requested frequently to identify specimens pertaining to medical entomology, these being suspected of influencing the mental or physical well-being of individuals in some real or fancied way. A wide variety of arthropod species have been examined and histories secured concerning their relationship to a specific medical problem. Some cases were of interest because of the infesting organism, *per se*, while others were of interest because of the peculiar circumstances of the case and the incriminations made prior to detection of, and/or the correct specific identification of the arthropod.<sup>1</sup> The cases that are reviewed here are considered to be representative of the type of problem in the practice of medicine which the parasitologist may be called upon to help solve.

### "Allergic" Dermatitis Caused by a Bug

Some 12 years ago, a student of one of our Indiana institutions of higher learning came to the writer with an insect for identification. He had been sent to us by a doctor of the Student Health Service of that institution. On examination the insect proved to be a bug, namely the bedbug, *Cimex lectularius*.

As in all of these cases, an attempt was made to determine the medical importance of the insect in reference to the particular case. It was learned that this student had been suffering from

a dermatitis for several weeks. The dermatitis was most prevalent on his arms. He had been given numerous sensitization tests in an effort to determine if the possible cause of his dermatitis might not be on an allergic basis. This bedbug was discovered by him on his arm one evening as he was doing some studying. The doctor whom he consulted instructed him to bring the insect to us for identification. On questioning, it was learned that the student sat in a particular wicker chair in the evening as he pursued his studies. He and another student were living in bachelors' quarters set up by them. Some of the furnishings had been obtained from a local dealer in used furniture. Investigation revealed that the chair was infested with bedbugs. The chair was burned and the dermatitis resolved without further treatment. Circumstances indicated that the dermatitis was caused by the bites of the bedbug.

### "Chickenpox" Caused by Insect Infestation

In July of 1952 an insect was brought to us for identification. This had been obtained from the head of a little girl of a family in which there were two children, both of whom had been suffering from a skin eruption initially thought to be chickenpox. When the eruption did not resolve in due time, the services of a dermatologist were sought. In making a thorough examination, the dermatologist, Dr. Robert E. Jenkins, found an insect, which he recognized as a flea, on the head of one of the children. It was brought to us for confirmation of his identification. It was the temperate zone rat flea, *Nosopsyllus fasciatus*.

In making further inquiry it was found that this family lived in an upstairs apartment, and that the attic above the apartment was being used as a den by squirrels. The fleas, (presumably from the squirrels), had gained access to the

\* A paper embodying the things about these cases that would be of principal interest to zoologists was presented before the Zoology Section of The Indiana Academy of Science at its Sixty-eighth Annual Meeting, October 17, 1952<sup>4</sup>.

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apartment, and their bites had caused an eruption, or dermatitis, on the children which had been temporarily misdiagnosed as chickenpox.

### Suspected "Arsenic Poisoning" in an Industrial Plant

On June 30, 1945, we received a summons from Dr. R. N. Harger, toxicologist at the Indiana University Medical Center, to come to his laboratory. On arrival the writer was introduced to the manager of a cafeteria of one of our large industrial concerns of the state. Accompanying him was an officer of the state police. On a table before them were some sandwiches. Two bites had been removed from one of the sandwiches; the other two were intact. The sandwiches were composed of buns and slices of bologna. At lunchtime that day, one of the industrial plant workers who was eating one of the sandwiches opened it and noticed some white material on the meat in the sandwich. It was thought that this white material could be arsenic, and due to wartime hysteria and the extreme precautions and warnings against sabotage, sufficient credence was given to this possible explanation, that this particular sandwich and two others from the cafeteria counter were transported to Indianapolis under escort of a state police officer. Doctor Harger made a preliminary examination of the white material on the sandwich in question, and failed to see any resemblance to arsenic or any chemical of that nature.

Upon macroscopic examination and with further examination under a binocular dissecting microscope, the writer identified the material as ova resembling those of a fly. The manager of the cafeteria wished more exacting proof of their identity, if possible, so we elected to incubate the eggs, and to make a positive identification of the larvae that might hatch from them.

The two intact sandwiches were placed, one each, in covered glass dishes in a refrigerator at a temperature of 40 F., and were kept as controls. At the end of 12 days the meat was not particularly discolored and still smelled fresh. Since nothing had been observed on these sandwiches, they were not given further consideration.

The sandwich in question was examined in detail. On both the bun and the meat there were creamy-white, cylindrical objects, tapering to-

ward rounded ends, and about 2 mm. in length. On one cut surface of the slice of meat there were six of these, two of which were used in making temporary mounts for immediate microscopic study. On the cut surface of one-half of the bun there were approximately 20 of these objects. Each half of the bun was placed in a separate covered glass dish, being laid on moistened filter paper. The meat was also placed in a covered glass dish, and these three dishes were kept at room temperature during most of the time of incubation and examination. On two occasions they were placed in an incubator at 98 F. for periods of three to four hours. Molds overgrew the half-bun on which no eggs were found. Likewise, the half of the bun on which there were some 20 eggs was overgrown by molds, and nothing of further significance occurred.

Three of the four remaining eggs on the slice of meat hatched on July 4, four days later, giving rise to worm-like maggots. The posterior spiracular plates were removed from one larva, and a specific identification was made on the basis of these. The larva was that of the green bottle-fly *Lucilia sericata*. The meat, of course, decomposed and made an excellent medium for the fly larvae. One of the remaining larvae was preserved for future reference, and the other was left in the dish. In a few days it pupated, but no further development occurred.

### Epidemic of Grain Itch Caused by a Mite

In 1909 and 1910 Rawles and Ray<sup>5,6</sup> reported on an epidemic of dermatitis, called grain or straw itch, which occurred in Allen County, Indiana. The etiological agent was a mite, *Pyemotes (Pediculoides) ventricosus*, which lives on the larvae of grain moths or joint worms that are in the stems of wheat or other plants. The mites transfer to workers who handle the straw from such infested plants. No further note had been made of outbreaks of this type of dermatitis until during the summer and autumn of 1950. During the course of the Indiana State Fair in the autumn of 1950 we received a telephone call from a physician concerned with the health of individuals in attendance at the fair. He made inquiry concerning the possible etiology of a dermatitis rampant among personnel and visitors at the fair. We suggested that the mite *Pyemotes ventricosus*, could possibly be the

etiological agent, and suggested means of control and prevention.

Later, Dr. Louis Spolyar, Director of the Industrial Hygiene Division of the Indiana State Board of Health, brought a sample of straw from the fairgrounds for our examination. We failed to isolate any of the mites from this straw at that time. It is possible that this straw may have been treated to destroy the mites, but we could not verify this suspicion.

On September 9, 1950, Dr. Spolyar brought some straw to us which he had obtained from an Indiana strawboard factory where grain itch was present among the employees. We isolated a mite from this straw and identified it as *Pycmotes ventricosus* (Fig. 1). A year later Dr. Boynton Booth who was interested in this problem, isolated mites from straw which he had obtained from the fairgrounds,<sup>1</sup> and we confirmed his identification of the mites as being *Pycmotes ventricosus*. Both years the straw used at the Indiana State Fair Grounds had been obtained from a strawboard factory near Indianapolis. Officials of the plant were unable to designate the exact area from which the straw had been obtained, originally, but did substantiate that it came from Indiana. It was estimated that some 1,700 cases of grain itch dermatitis were treated during the sessions of the state fair in the years 1950 and 1951. Booth and Jones<sup>1,2</sup> have written an excellent account of this epidemic and have brought together much useful information concerning this problem in the United States and the world. Davis<sup>3</sup> reported concerning the 1950 epidemic of grain itch in Indiana, and explained how its occurrence became possible because of the bountiful supply those years of the hosts (larvae of the grain moths and joint worms) on which this mite is predaceous. This experience has illustrated how certain arthropods, such as the grain itch mite, may be responsible for diseases of major importance, and in epidemic proportions, at undetermined, widely-separated times.



Fig. 1. Adult female *Pycmotes ventricosus* isolated by the writer from straw obtained at an Indiana strawboard factory by Dr. Louis Spolyar. Photomicrograph by Mr. James Glore. Actual size, 180 microns long.

### Conclusion

Four unusual cases of arthropod infestation are reviewed. These emphasize the important role that the parasitologist may have in the solution of medical problems, provided the indication for his services is recognized and, further, that his services are sought. Even though it is conceded that parasitic diseases do not present as great a problem in temperate regions as they do in the tropics, and that the problems pertaining to medical entomology are the least of these, the examples cited herewith indicate that even in temperate regions the trained parasitologist may make a major contribution toward the solution of problems relating to the health of individuals and the public. These cases further emphasize that the physician should always be aware of the possible presence of parasitic diseases or infestations, regardless of the climate of the region in which he practices medicine.

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*An Abstract:*

**AMERICAN JOURNAL OF OBSTETRICS  
AND GYNECOLOGY: 66:1127, November, 1953**

Wharton reports a study of 63 women with stress incontinence who were treated by the nonoperative treatment which was recommended by Kegel in 1949. These women varied from 20 to 60 years of age and the majority of them had borne children. In this group there were 13 patients with urological conditions. In these patients the disturbance could have been urge and not stress incontinence; the author does not differentiate these two conditions. In 28 of the patients the stress incontinence was in some way associated with uterine or vaginal prolapse or cystocele. It is noted that urinary incontinence frequently occurs after operations for cystocele and uterine prolapse.

In general, in the 63 cases the results of the exercises were as follows:

- Cured 30 per cent
- Improved 51 per cent
- Unimproved 19 per cent

The exercises consist of frequently repeated voluntary and strong contraction of the muscles that stop or prevent urination. The patients are instructed to make the same effort they do to prevent the flow of urine when the bladder is filled. This exercise is repeated at least 15 times, three times a day.

**Conclusions**

1. If a woman has prolapse or any definite gynecological disorder which requires surgical treatment, and also has stress incontinence, we think the indicated gynecological operation should be performed. At the same time, a suitable operation may be done to correct the stress incontinence. If the patient continues to have stress incontinence after this treatment, exercises should be used.
2. If a patient with stress incontinence and prolapse cannot be operated upon, the stress incontinence may be treated by exercises.
3. If stress incontinence develops after an operation, exercises have been useful.
4. In urological conditions complicated by stress incontinence, exercises supplement urological treatment.
5. Other factors are also worth consideration in treating stress incontinence—obesity, nervousness, and worry.

The simplicity of this method of treating stress incontinence recommends it. Exercises cannot possibly do any harm; they involve no expense or inconvenience. If they fail, nothing is lost; if they succeed, an operation may be avoided.



# The *Journal*

of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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## WE INVITE YOU TO "TELL A STORY"

**A**NNOUNCEMENT is hereby made of a new department of THE JOURNAL. This "department" will not have any formal name, and will probably not have any special heading in the magazine itself. It consists actually of an adventure in editorial policy which will seek to encourage the writing and publication by its readers of a variety of material which might be described collectively as the human interest side of medicine.

To put it in a different way, we are interested in that part of the doctor's life apart from the practice of medicine itself—hobbies, anecdotes, human interest stories—all things not a part of medicine yet still connected with it in some way.

A hobby is defined as a favorite subject of discourse. Everyone is interested in some hobby, and everyone is interested in the hobbies of others. Hobbies, especially if they can be presented with illustrations, make splendid subjects for entertaining articles. THE JOURNAL has already included some presentations of this sort

and wishes to encourage more writings of this type.

Humor is a saving grace in a world which often seems to be too serious. It is well to share the humorous anecdotes which come our way. We believe that our medical journal may well devote space for this purpose; contributions of humorous nature are solicited.

The practice of medicine, as all doctors realize, presents a kaleidoscopic array of all aspects of human nature. Mixed with the problems of medical care the physician encounters daily the situations upon which the world's greatest stories and much of its literature is based. Each of us at times has witnessed tragedy, humor, irony, love or intrigue which would rival fiction itself.

Good fiction is written by authors who follow the simple rule of writing about the things they know best, about the every day happenings around them, and about the people with whom they live their lives.

All this variety of subjects are things about

which a doctor may write, and in which other doctors will be interested. Contributions for this new "department" are now being sought. Articles may be published anonymously, with a nom de

plume, or with a by-line. Our readers are urged to relax once in a while amidst the toil of medical practice, and write of some of the interesting and unusual things which occur every day.

## THE STATUS OF SCIENTIFIC EXHIBITS

WE FEEL that Scientific Exhibits have a very real place in the yearly meeting of the Indiana State Medical Association. The greatest number of exhibits were shown in the Centennial year through the prodigious efforts of Dr. Thurman Rice. Ever since that time, the number of Scientific Exhibits has gradually dwindled until last year, at French Lick, we had the low of only four Scientific Exhibits.

We, the members of the association, have within our power the ability to develop this facet of the annual meeting to what we want it to be. If we think exhibits have use and add to the meeting by encouraging members in the organization to exhibit their achievements or interesting parts of their work, we can add another teaching element to these conventions. There is a very definite place for scientific teaching by exhibits. The ideal exhibit is one in which a man shows some phase of the practice of medicine in which he is interested and which he has followed prob-

ably beyond the experience of many other physicians. Many physicians in Indiana, in their own practice or in their hospital connections, have done some type of study or procedure which might be useful to their conferees, and an exhibit at the State Medical Convention is an opportunity to pass this information on to others to whom it may be of value by visual education. It is true that preparing an exhibit is a task, it costs money; however, whoever prepares an exhibit gets the most out of it because in crystallizing his ideas or facts so that they can be shown to others in a simple condensed fashion, he, the producer of the exhibit will learn many things in his own work which he previously had not considered or recognized.

Not infrequently during the course of an exhibition the exhibitor has been astonished to discover a whole new train of thought stimulated by questions asked him by viewers of the exhibit.

Harold D. Caylor, M.D.

## AMERICAN MEDICAL EDUCATION FOUNDATION

THE TWO NATIONAL FUNDS for aid to medical education had a record year in 1953. Both received an unprecedented amount of money, and also experienced a much broadened base of support by enlisting more contributors than in any previous year.

The American Medical Education Foundation passed the million mark for the first time. A total of \$1,089,962.93 was contributed by individual physicians, organizations and laymen. This represented an increase in number of donors of 149 percent over 1952.

The National Fund for Medical Education,

the fund which was organized to seek the gifts of industry and business, was benefited by a total of 994 corporations to the tune of \$1,367,979.00. Their increase over 1952 was 74 percent in contributions and 193% in donors.

This achievement is heartening, not so much because of the amount of money raised, which is of course "not hay," but even more so because of the broadened base of contribution. At the outset everyone realized that the financial need of the 79 medical schools was so acute that a few doctors and a few businesses could not possibly solve the problem. Both the funds were

started on the premise that the problem could be solved if a large number of individuals and industries participated, and that it could be solved by a large number of participants without financial hardship for any of them.

The fact that the membership in these funds is rapidly increasing is a good sign. The financial plight of our medical schools shows no signs at present of being a short-term affair; the need for outside assistance may continue for many years. The sooner the load is spread over as much territory as possible the better for all.

One of the best things about the American

Medical Education Foundation is that there have never been any set dues or assessments. All physicians may contribute according to their means; donations of any size, large or small, are always gratefully acknowledged. Every doctor in practice graduated from some medical school, and probably received much more from his school than he paid out in dollars. Now is a good time to repay part of the difference.

Indiana was one of the leaders in the nation in building up the record total in 1953. What say we lead them in 1954 and make the state total another whopper that can't be beat?

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### TV GUIDE TAKES THE DOCTOR'S VIEWPOINT

A recent TV Guide magazine editorial tore into the CBS-TV Strike It Rich programs and upheld the viewpoint long held by the medical profession.

The editorial started out by saying:

"It must be a cinch to write for the Daily Worker, Pravda and other Communist sheets as long as TV press agents dish out publicity releases like this one:

"'Even though she failed to win the top cash prize on the CBS-TV Strike It Rich program, Mrs. ———, of Philadelphia, "struck it rich" . . . when she appeared as a recent contestant. In desperate need of medical aid, Mrs. ——— won \$115 toward it, but through the show's heart line telephone, she received an additional \$100, plus free medical treatment for as long as she may need it.'"

Then the magazine's editorial said:

"Can't you just hear the Red propagandists citing that as proof that the poor in America must bare their misery on television shows in the hope of winning medical treatment?

"The fact is that the poor in America receive medical care as good as, if not better than, anyone else. Leading doctors give unstintingly of their time, and hospitals and clinics of their facilities, so that those who require treatment and can't afford it can be helped—without charge. No one, especially in a great medical center such as Philadelphia, has to be 'in desperate need of medical aid.' No one has to appear on television to ask for such aid.

"In all fairness to Strike It Rich, the program did not originate the idea of using human misery as a form of entertainment. Nero, for one, had a great time with it. If, today, a television show can thrive on misery, and if that's what viewers want to see, the sponsors of the show have good reason to keep it on the air.

"But we can, and do, object strenuously to stupid publicity material that presents a false picture of our way of life in order to grab off a few lines of newspaper or magazine space."



# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

The Tenth Annual House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association will be held April 6 and 7, Lincoln Hotel, Indianapolis.

The final plans for the entertainment of the Auxiliary delegates are being made in Indianapolis by the Woman's Auxiliary to the Indianapolis Medical Society headed by Mrs. Morris B. Paynter, President.

### CALENDAR OF EVENTS

April 6, 1954

Registration 9:00 A.M.-5:00 P.M., Lincoln Hotel, 14th Floor (Lobby)

Board Meeting 10:30 A.M. Travertine Room

(This includes all State Officers and Committee Chairmen, County Presidents and Presidents-Elect, District Councilors)

General Session 1:00-4:00 P.M.

Banquet 7:00 P.M. Travertine Room, Guest Speaker, Dr. I. Lynd Esch, President, Indiana Central College

April 7, 1954

Breakfast 8:45 A.M. Travertine Room (MEMORIAL SERVICE)

General Session, (continued) 10:00 A.M., Lincoln Room

Luncheon 1:00 P.M. Guest speaker—Mrs. Leo J. Schaefer, President, Woman's Auxiliary to the A.M.A.

Post-House of Delegates Board Meeting

Wednesday afternoon will mark the installation of the newly elected state officers and the retiring state president, Mrs. W. Burleigh Matthew, Indianapolis, will be succeeded by Mrs. Harry C. Harvey, Fort Wayne.

# The President's Page

FELLOW MEMBERS OF I.S.M.A.:

I ATTENDED the Regional Legislative Conference of the American Medical Association in Chicago on February 6, 1954, together with several members of our Committee on Public Policy and Legislation. The purpose of this meeting was to discuss the most important issues to be considered during the second session of the 83rd Congress.

The item that received the most attention was the subject of Social Security coverage for the physician. It had been assumed that most physicians were against being covered, however, as the subject was discussed and the results of some of the polls were reported many of us were in the dark as to which way the profession really wanted to go.

Here are some of the facts pointed out in favor of it under the proposed new law:

1. The monthly payment may be increased to as much as \$120.00 a month.
2. Only your current earnings are involved. Your income from investments is not figured in the amount you can earn each month before you are ineligible for Social Security that month.
3. Earning over the required amount one month only takes you off the list for the month involved.
4. This would require a 3% payment on the first \$3,600.00 of your income.
5. Payment to the physician to begin at 65 years of age if he did not earn over \$1,200.00 annually with no penalty and it would require \$2,300.00 to stop his benefit entirely. (The present law makes the maximum benefits \$85.00 a month for the physician and \$42.50 for his wife if she is over 65).
6. There is a provision in the present law that, if you die before 65 and leave a widow and one child under 18 years of age, and your earnings have been over \$300.00 a month, your family would receive \$127.60 a month until the child reached 18 years of age. Your widow at 65 would receive \$63.80.

Now to look at the other side of the picture. Some men feel that in accepting Social Security we are condoning the socialistic trend that is overtaking the country. Most doctors work as long as they are able which is usually until they die. Many men well able to retire continue to work because they love it. If this is so, a large amount of the money paid on Social Security goes down the drain. Further some feel that this is not an insurance plan because the excess of premiums over outgo is used by the Federal Government and an I.O.U. put in to take its place in the form of Government Bonds. This being so, future payments will have to come out of the young workers' taxes at the time these payments are made.

Would you write the Indiana State Medical Association your feelings on this matter for the guidance of your committee?

There is one proposal I believe we are all agreed on, that is to allow tax deferments on premiums used to purchase retirement annuities.

My last thought is: If the dollar continues to depreciate maybe we had better buy land that will increase with the dollar and not depend on either annuities or Social Security.

It is always discouraging to discuss current issues in a page that goes to print a month before you read it.

*Wm Harry Howard M.D.*

## FEDERAL CIVIL DEFENSE HEALTH PROGRAM REVIEWED AT AREA MEDICAL CONFERENCE

The following address was presented at the Fourth National Target Areas Medical Civil Defense Conference on November 15 at Cincinnati by Norvin C. Kiefer, M.D., former director of the Health and Special Weapons Defense Office and now chief medical director for the Equitable Life Assurance Society of the United States and acting consultant to the Federal Civil Defense Administration. It is published here by special permission of Doctor Kiefer.

IT IS A PLEASURE to be here today, among old and good friends, to give my last general report on the status of the Health and Special Weapons Defense program of the Federal Civil Defense Administration. As you know, I resigned from my position as Director of the Health and Special Weapons Defense Office to become, on August 1, the Chief Medical Director of the Equitable Life Assurance Society of the United States. I am sure that most of you recognize my intense interest in National Civil Defense. Therefore, I believe you will realize that when Governor Peterson asked me to continue as a consultant to Federal Civil Defense Administration and to become a member of his medical advisory committee, I considered it a privilege to continue my association, in this capacity, with a cause to which I am devoted: civil defense.

I said this is my last general report on the Health and Special Weapons Defense status of Federal Civil Defense Administration because that program is moving along so rapidly that without continuous contact with it, it is impossible to keep abreast of the many developments and accomplishments.

Actually, Dr. Robert Flinn, the new Director of Health and Special Weapons Defense activities of the Federal Civil Defense Administration, should be giving this talk today. When I accepted your invitation many months ago, it was without knowledge that by the time of your meeting I would be in a new field of work. Dr. Flinn requested me to keep my commitment. Much has happened in the three months since I left, so much that Dr. Flinn probably will have to answer any questions which you may have.

I derive a special pleasure from meeting with

this particular group. I believe I am correct in my appraisal that in my civil defense work I have had no more severe critics—and no better friends. I hope and ask that you give my successor, Dr. Flinn, and his associates, the same support and cooperation, and the same open, friendly criticism, devoid of malice but in the spirit of helpfulness, that you have given me in the last few years. It is you—and devoted physicians like you—who, in the last analysis, will determine the success or failure of our nationwide medical civil defense program.

Most of the task ahead must be assumed by you, and others in the local and state official agencies, and in the professional organizations which are supporting and working with them. Your colleagues in the federal agency will continue to do everything in their power to assist you but compared to your potential contribution, theirs is relatively insignificant. You, individually and collectively, not a small group of professional people in Washington, D. C., are civil defense. It cannot be otherwise, nor should it be, because civil defense is a responsibility of every citizen of the United States.

I am going to digress a moment to tell you of a truly thrilling moment in civil defense I have had since assuming my new position. The home office building of the Equitable Life Assurance Society is located directly across from Pennsylvania Station in New York City, on Seventh Avenue. This location has a direct bearing on the rest of my story, otherwise I would hesitate to mention it lest you wonder why one who is as familiar with critical target areas as I am would accept a position that involved working in a location so vulnerable to sharing the devastation of enemy attack on the United States. For many



of you, however, and millions of other Americans, the location of your place of work was determined long before the grim specter of atomic attack on American civilians was ever dreamed of. We gamble because we must, while indulging in wishful but uneasy thinking of the future.

To continue, a few weeks ago New York City staged a civil defense alert. I made an inspection tour of the building after the air-raid warning, and finished in time to have a surreptitious glance, from my office on the seventh floor, out onto Seventh Avenue. Most of you have, at some time, entered or emerged from Pennsylvania Station in New York City and will remember the rushing crowds; the street glutted with taxicabs, trucks, pushcarts, and teeming humanity; the noise; and, at least to a stranger, the frightening hustle and seeming confusion.

### New York Alert Thrilling

But on this particular day, during the air-raid exercise, I looked down on Seventh Avenue of New York City at 9:30 on a weekday morning on what looked more like Main Street of a small village at three o'clock on a Monday morning. My view commanded the area from Thirtieth to Thirty-third Street. Instead of rushing thousands, the only sign of activity was one lone air-raid warden, standing under his helmet, at Thirty-second Street and Seventh Avenue. There was no moving vehicular traffic. A number of taxicabs, deserted by both cab drivers and passengers, lined the curb on both sides. This was a busy street, at a busy hour, in the largest city in this nation of large cities. It was utterly deserted and silent, in a thrilling demonstration of public cooperation.

A few seconds later the all-clear signal was sounded; thousands of people streamed out of the buildings; cab drivers and their fares climbed back into the deserted taxis; business was as usual. But for those few seconds I stood in silent emotion. To me, the simple dramatic, yet grim scene I had witnessed denied the frequently heard accusation that the American public is too preoccupied with business, and too complacent and apathetic about possible enemy attack, to give even a semblance of cooperation to civil defense. For those few seconds, all the frustration and discouraging experiences of my last few

years faded, to be replaced by a heart-warming realization that our work—yours, mine, all of us who believe in civil defense—is at least beginning to show tangible results, results which may eventually determine our national ability to survive.

Forgive me my moment of sentimental reflection, but I know this group would have shared my emotions. Otherwise, you would not have sacrificed the time and spent the energy you have in the last few years; in fact, you wouldn't be here in Cincinnati today.

Without hesitation, I will say that the Federal Health and Special Weapons Defense program is distinctly over the first big hump. There is still a long way to go, but in many phases of activities, the pace necessarily will decrease from now on until states and cities have advanced farther. The real strength of national civil defense health services activities must ultimately be measured in terms of the extent and effectiveness of first, local and then state organizations.

Last May we invited 10 representatives of your group, and of the Council on National Emergency Medical Services of the American Medical Association, to Washington for a briefing session on the status of the Federal Health and Special Weapons Defense program. It lasted two days, two packed, busy, and rather exhausting days, and even then we could only present highlights of most of our program, and had to omit some of it entirely. I believe this was an extremely valuable meeting which I hope can be repeated.

The Federal Civil Defense Administration did have nine regional offices, but effective June 30 two were closed, leaving seven, in or near Berkeley, Dallas, Denver, Chicago, Atlanta, Philadelphia, and Boston. There is a regional medical officer in each. These regions correspond closely to the army areas except that the Fifth Army Area encompasses two Civil Defense regions with headquarters in Joliet, Illinois and Denver.

To help implement health and special weapons defense programs within regions, each region has a health services advisory committee composed of representatives of the state health officers and the state medical, hospital, nursing, dental, veterinary, and pharmaceutical associations of the states within the region. The na-

tional organizations of each of these groups nominated the regional representatives.

The fiscal year 1954 appropriations request of the Federal Civil Defense Administration was based on 11,000,000 casualties potentially resulting from enemy attack on American cities. Of these, it was estimated that over 7,000,000 might survive the immediate effects of the attack and, therefore, present varying degrees of medical and surgical care problems. As enemy weapons potentials increase, doubtless these casualty estimates will be revised upwards.

### Keyed to Resources

The Federal Civil Defense Administration casualty care plans were based on the estimated maximum number of casualties to whom minimum surgical and medical care could be provided within a brief period of successful enemy attack. The key to these estimates is the maximum number of physicians and allied professional workers who could be mobilized and concentrated near attack areas, and the number of hospitals that would be available—surviving existing hospitals and adequately equipped improvised hospitals.

With full consideration of these limiting factors, it was computed that the maximum number of hospital patients to whom care could be furnished would be 3,300,000, the number of hospital casualties resulting from a total of 5,000,000 surviving casualties of all types. It is not implied that for casualties in excess of this number no care could be provided. The objective must of course be to provide life-saving care for all casualties, regardless of number. But one must be realistic and admit that beyond the figures I have given you—and perhaps considerably before they have been reached—the kind of casualty care necessarily would become more and more subminimal.

Thus far, Federal Civil Defense stored supplies are distinctly inadequate for even 5,000,000 surviving casualties, with 3,300,000 hospital patients. At the close of the last fiscal year, Federal supply orders provided for the first week of care for 2,000,000 surviving casualties. Almost all of these supplies have been delivered and stored in thirteen Federal warehouses. In fiscal year 1954, it will be possible to increase these amounts to provide for the second and

third weeks of care but for the same number, 2,000,000, of casualties.

Part of the supplies stored in Federal warehouses are being assembled in functional units. There are four main groups of such units:

- 1) A 100 casualty group of supplies for peacetime disasters.
- 2) A replenishment group of back-up supplies to keep a first-aid station in operation for the first 24-48 hours.
- 3) A replenishment group of back-up supplies to keep a 200 bed improvised or existing hospital in operation for the first week.
- 4) A replenishment group of supplies for a blood center to collect 1,000 additional blood donations.

A Technical Bulletin is being prepared to provide exact details on these functional groups.

The Health and Special Weapons Defense Office painstakingly obtained the advice and recommendations of some of the most authoritative groups in the country before formulating its supply lists. Once the lists were adopted, however, exceptions could not be permitted if the Federal Civil Defense Administration were to build reserves expeditiously, maintain uniformity and efficiency and, at the same time, conserve productive capacity and federal and state funds. The latter considerations, incidentally, already have saved taxpayers several million dollars, chiefly because the administration took advantage of greatly reduced prices resulting from quantity buying concentrated on a minimum of essential categories of items. To the occasional complaint that the items in some cases are not the most useful ones for everyday civilian medical practice, my answer is that these supplies were carefully selected for mass casualty care and they are being stored for civil defense, not for normal peace-time use.

Please remember that in an emergency it is a responsibility of your state and city to be able to receive these Federal Civil Defense supplies and promptly assign and deliver them to where they are needed in a devastated city.

Federal Civil Defense Administration plans are based on target areas being prepared to meet their own needs for the first few post-attack hours, until federal reserves could arrive. First



aid stations would be needed immediately following enemy attack. Federal funds have been made available to states, to pay half of the cost of first aid station initial supplies.

Supplies for over 6,900 out of an estimated minimum nation-wide need for about 8,000 such stations have been purchased by and delivered to the states, using federal contributions funds to pay for half. This is highly encouraging but it is not quite as favorable as it first seems. Some states have bought their full requirement and, in addition, a reserve to compensate for losses from enemy attack. Other states have bought practically none.

### First Aid Manuals Ready

The federal agency has published detailed recommendations, in technical manuals, for the organization of first aid systems. But it is you, not the federal government, who can bring such systems into potential being, who must recruit and train personnel—professional and auxiliaries from the general public—and institute practices and test exercises. In the interest of reasonable uniformity I hope you will carefully consider these federal recommendations. But only a local group can decide whether the suggested system fits conditions peculiar to the particular target area. If it doesn't, it is the task of the local group to modify the system so that it does. And the only Civil Defense Agency that can implement it is the local one.

I hope that all of you have seen the detailed recommendations and specifications for a standard casualty record system, published by the Federal agency, which made available, under the federal contributions program, uniform emergency medical service tags for all casualties. Every state has adopted this standard system and, with slight modification, so has Canada.

Of the 3,300,000 casualties needing hospital care, less than 1,000,000 could be cared for in surviving existing hospitals in and nearby all critical target areas. Even the estimate of 1,000,000 assumes tripling of existing bed capacity in each surviving, existing hospital and its adjoining buildings, and it still leaves 2,300,000 patients to be cared for in improvised hospitals—and if there is any error in this estimate it is one of being conservative!

After adaptation of the Mobile Army Surgical Hospital to civil defense purposes, standard equipment lists, with detailed specifications, for improvised hospitals in schools and similar, suitable buildings, were devised and distributed. These items are now eligible for federal contributions funds for states with critical target areas. With the cooperation of the Armed Services Medical Procurement Agency, the State of New York, and the District of Columbia initial work on the most effective assembly and packaging methods has been completed.

A technical bulletin on "Acquisition of Narcotics During an Emergency" will soon be released. It will include administrative procedures for requisitioning local stores of narcotics from retailers, wholesalers or wherever narcotic supplies are held, including local and branch offices of the Federal Bureau of Narcotics. A sample of a special order form will be part of the bulletin. Quantities of these forms will be available to state and local civil defense officials or their designees. 32,000,000 doses of morphine, earmarked for civil defense from other federal stocks, have been dispersed to key points in the United States.

I am sure that all of you know of the detailed manuals on civil defense activities published for nurses and for dentists. Civil defense technical training courses have been stimulated for both of these professional groups.

A technical bulletin outlining in considerable detail courses for the training of first aid technicians, a sort of civilian hospital corpsmen, and other first aid station personnel, has been issued. Another, on organization and operation of civil defense mortuary services, is nearly ready.

An excellent manual on emergency medical treatment, prepared by the National Research Council, was published in June. It should be extremely useful not only to dentists, veterinarians, nurses and others who will assist physicians in the care of casualties but also to the physicians themselves.

A new family handbook, entitled "Before Disaster Strikes—What to do now about Emergency Sanitation at Home", has just been published.

I hope all of you have seen the new recommendations, devised by the National Research Council, on the use of the tourniquet. The



American National Red Cross has accepted and published these recommendations which constitute a distinct change in previous instructions. For example, it is now advocated that once the need for use of a tourniquet has been determined and one has been applied, it is not to be released at intervals as previously taught, but is to be left in place until it is released by a physician who is prepared to control hemorrhage surgically.

Many of you have seen the Federal Civil Defense Administration laboratory kit. Since your last meeting, this kit has been tested and found to be highly satisfactory for all emergency purposes, in three leading hospitals. Each Federal Civil Defense Administration regional office has a kit available for demonstration purposes.

The Federal and State Civil Defense agencies now have on procurement 4,000,000 blood donor and recipient sets with bottles. 1,300,000 units of plasma are now available and more is on order. 300,000 units of dextran and 1,200,000 units of PVP (polyvinyl pyrrolidone) are stored in federal warehouses, and 1.3 million more units of expanders are on order. Plasma expanders can also be purchased for state and local civil defense reserves with half of the cost available from federal contributions funds.

In radiological defense, a number of publications on emergency permissible exposures to radiation, on recommended precautions related to radiation hazards, and on various types of radiation detection instruments have been issued. Temporary loans of training instruments to a number of civil defense agencies have been arranged. In addition to the many physicians, nurses and radiological monitors who have been trained in the fundamentals of their respective radiological defense fields, instruction has been given to radiological monitoring leaders and teachers at the Atomic Energy Commission test grounds in Nevada, so that these people could have experience with actual post-bombing radiation detection and measurement.

### New Mask Developed

In Chemical Warfare defense a cheap gas mask for general civilian use has been developed and tested, by the Army Chemical Corps. A medium duty mask for civil defense workers also has been developed and is available in limited quantities on the federal contributions list, for

state purchase. The Federal Civil Defense Administration has stimulated and participated in the development of various new types of injector devices for atropine to be used for chemical warfare victims. No manuals on chemical warfare defense have been published because of the availability of excellent military publications.

In the field of Biological Warfare defense—human, animal and crops—a great deal has been accomplished in spite of insufficient funds. Antibiotics and certain biologicals or standby equipment for emergency production of biologicals have been stored. A specialized laboratory diagnostic system, using university and Federal agency laboratory facilities, is well started under the sponsorship of the Public Health Service. Training programs for key officials and technical experts have been made available with the cooperation of other government agencies. An interagency human, animal and crop disease reporting and evaluation system, coordinated by the Federal Civil Defense Administration, is now in operation. An excellent new four-part technical manual on biological warfare defense has just been published and copies have been distributed to you today. Dr. John Phair, who is attending your meeting, deserves a great deal of credit for the success of this project.

What will be the Federal Health and Special Weapons Defense activities during the balance of fiscal year 1954? Practically all of the basic technical manuals and bulletins have been published or are near completion, but they will need constant review to make appropriate revisions. Detailed federal emergency operational procedures must be improved and tested, and then revised as indicated. Technical assistance to states must be expanded. Federal supply packaging and distribution methods must be brought to top efficiency. Methods must constantly be appraised in the light of changing enemy weapons potentialities.

All of this must be carried on in spite of sharp budgetary restrictions imposed on the Federal Civil Defense Administration. For fiscal year 1954, Dr. Flinn and his staff have again suffered a severe reduction in appropriations, from a request of over \$88,000,000 to less than \$27,000,000 and, therefore, civil defense improvised hospital and medical supply and special weapons defense research programs must be contracted or postponed; an already numerically inadequate

staff is threatened with further personnel reductions; travel funds have been sharply reduced; even the name of the office has been abbreviated, from "Health and Special Weapons Defense Office" to, simply, the "Health Office"! But their enormous responsibilities have not decreased in the least. In fact, new responsibilities have been added: coordinating of federal government activities in peace-time disasters.

Without doubt, many of you are wondering what will be the effect, on your existing plans, of recent developments in enemy weapons. I can best summarize this situation for you by quoting to you from the most authoritative, the most informed, the highest official of our country: the President of the United States. These are excerpts from a statement made, on October 8, 1953, by President Eisenhower:

"You will recall that our government announced that the Soviet produced an atomic explosion in 1949 and two subsequent explosions in 1951. In August of this year we learned through intelligence channels of a Soviet test of an atomic device, in which some part of the explosive force was derived from a thermonuclear reaction, that is to say, what is popularly known as the H-bomb. The Atomic Energy Commission announced this August 12th detonation as soon as sufficient evidence was in hand, and later announced that it appeared to be part of a test series.

"The development did not come as a surprise. We had always estimated that it was within the scientific and technical capabilities of the Soviets to reach this point and we have been on notice for some years that their own ingenuity has had the material assistance of what they learned of our program through espionage.

"The Soviets now possess a stockpile of atomic weapons of conventional types and we must furthermore conclude that the powerful explosion of August 12th last was produced by a weapon, or the forerunner of a weapon, of power far in excess of the conventional types.

"We, therefore, conclude that the Soviets now have the capability of atomic attack on us, and such capability will increase with the passage of time."

These are the words of our President. It was inevitable, of course, that Russian scientists would follow the lead of our own, and constantly

improve the original new weapon that they tested in 1949.

What do these events portend for your plans? My only answer is that they demand that as rapidly as possible you perfect your plans for defense against even the Hiroshima type of bomb, and that you complete your proposed organization for medical civil defense against this 1945 vintage attack. When you have done this, you will be ready to start expanding these plans to meet the fantastic destruction which is a potentiality of much larger atomic bombs and thermonuclear weapons.

But you cannot expand or revise operating procedures until such time as you at least can truthfully say that your initial procedures have been developed to the point where you can put them into action, with a guarantee of effectiveness, at any time. In other words, do not postpone your work with worry about how to meet the threat of a 10 or 20 X bomb, or any other multiple of X you wish to imagine, but first become really ready to provide health services to the victims of attack by a number of even 1 X bombs.

Your ultimate objective can be only to provide the greatest possible amount of health protection, to care for the maximum number of living casualties, up to a point where it would be humanly impossible to do more. If you have attained this objective, what difference does the TNT explosive equivalent of the bomb make to your basic plans?

This is a brief summary of some of the major activities, the current status of work, and the fiscal year 1954 plans of the Health Office of the Federal Civil Defense Administration.

Now I am going to take advantage of my own altered status to say something which would not have been appropriate for me to say at your previous meetings. Like yourselves, I am now a private citizen. Therefore, it is without any personal interest or advantage at stake, that I appeal to you for your continued and expanded support of your colleagues in the Federal Civil Defense Administration. I know intimately of their great professional and technical competence, their devotion and loyalty to civil defense, and I also know the frustrations and the discouragements which they have faced. These people are your professional colleagues and your

friends. Against disheartening odds, they have done their utmost to support you, to provide you with every sort of aid they could.

### Task a "Thankless One"

The material they have published has been well-considered and sound, even though it could not possibly always be completely applicable to every detailed situation which might arise in every state and city in the United States. Everything they have issued has constituted, to the maximum possible extent, a consensus of a large and representative group of experts from widely scattered areas of this, and sometimes other countries. The delays in publication of some of their information have been due, almost without exception, to circumstances completely beyond their control.

In general, theirs has been a thankless task, and their many accomplishments have been recognized by a distressingly small number of even their own professions. No one should be able to appreciate these facts better than you, who doubtless have encountered similar discouragement.

All I ask of you now is that you give to them the same support, the same understanding, that they have tried their best to give you. Your objectives are the same. To attain them, you must work together, you must share the blame for in-

adequacies and the credit for real accomplishments.

Finally, what can I say to encourage you? With insufficient cooperation and understanding from many of your professional colleagues, you have maintained your interest, you have continued to sacrifice your time and efforts for a cause in which you believe. I again pay tribute to you: You are a credit to your profession.

On previous occasions, you have heard me close my remarks with my own words of encouragement to you to persist in your efforts. It is a pleasure at this meeting to be able to close with a direct quotation from President Eisenhower. On October 13, 1953, he said to the Directors of State Civil Defense Organizations assembled at the White House:

"Please don't get discouraged when you feel no visible progress. It is awfully hard to awaken people to a sense of responsibility without trying to create hysteria—which we certainly don't want to do. It is awfully hard to awaken people to a sense of responsibility that produces a steady and periodic work or effort.

"We must be real leaders. We must never be discouraged. So no matter what happens, no matter what things look like at the moment, please keep going."

In conclusion, you have my best and warmest wishes for continued success in your endeavor for local civil defense health programs.

## *Nu Sigma Nu Invites All Physicians to Attend the* **Fifth Annual Burton Dorr Myers Lecture\***

### **"Physiological Aspects of the Treatment of Gastric and Duodenal Ulcers"**

*presented by*

DR. LESTER DRAGSTEDT

Professor and Chairman, Department of Surgery  
University of Chicago

**Saturday Evening, March 27, at 8:30 p.m.**

in the Auditorium of the  
Indiana University School of Medicine

\* Established in 1950 by Beta Eta chapter in Recognition of the Contributions of Dr. Myers, whose death occurred a few months later, in the establishment and development of the Indiana University School of Medicine.



## I. U. SYMPOSIUM ON MALIGNANCY TO FEATURE PAPERS ON CANCER OF THE LUNG

A RECORD ATTENDANCE of physicians from all parts of the state is anticipated for the seventh annual postgraduate Symposium on Malignancy, being held Wednesday, April 7, at the Indiana University School of Medicine.

The symposium this year is being devoted to discussion of cancer of the lung, a subject of wide interest at this time due to conflicting statements regarding the role which cigarette-smoking may play in this particular type of cancer. Results of laboratory studies involving mice in which epidermoid cancers have been induced, will be presented by one of the speakers.

Major emphasis, however, will be on the advances in early detection, more certain diagnosis, and treatment of cancer of the lung. Eight speakers, each of whom has won recognition for research and clinical work with pulmonary cancer, will participate in the symposium program which opens at 9 a.m. and continues through the afternoon.

In addition to the formal symposium, the eight visiting speakers will also participate in a Cancer Round-Table to be presented Tuesday evening, April 6, in the auditorium of the School of Medicine. This program is also open to all physicians of the state and they are invited to submit written questions on any phase of cancer, for discussion by the panel. These questions should be mailed in advance, addressed: Cancer Committee, Indiana University Medical Center, 1100 West Michigan street, Indianapolis.

Physicians interested in attending both the Round-Table and the Symposium, will find a limited number of guest rooms available at the new Student Union building on the Medical Center campus. Reservations should be made in advance.

Both the Symposium and the Round-Table are being presented by the School of Medicine,

again with the cooperation and support of the Indiana Division, American Cancer Society. The Indiana Division has been an important factor in the stimulation of both professional and lay interest in the cancer problem and in both direct and indirect support of cancer research by the School of Medicine.

The speakers and subjects for the symposium, to be presented in the auditorium of the School of Medicine, include:

### Morning Session—

“Radiological Interpretation of Pulmonary Shadows”, Dr. Lawrence L. Robbins, Assistant Clinical Professor of Radiology, Harvard Medical School.

“The Value of Mass Chest X-Ray Surveys in the Detection of Early Carcinoma of the Lung”, Dr. R. J. Anderson, Medical Director and Chief of the Division of Disease and Tuberculosis, U. S. Public Health Service.

“The Cytological Diagnosis of Pulmonary Cancer”, by Dr. N. Chandler Foot, Emeritus Professor of Surgical Pathology, Cornell University School of Medicine.

“The Possible Influence of Smoking on the Origin of Pulmonary Cancer”, by Dr. Evarts Graham, Emeritus Professor of Surgery, Washington University School of Medicine.

### Afternoon Session—

“Potentialities of Chemotherapy in the Treatment of Pulmonary Carcinoma”, by Dr. David Karnofsky, Associate Professor of Medicine, Sloan-Kettering Division of Cornell University School of Medicine.

“The Importance of Surgical Exploration of Obscure Pulmonary Shadows”, by Dr. Herbert C. Maier, Assistant Clinical Professor of Surgery, Columbia University.

“Results of Surgical Therapy of Carcinoma

of the Lung", by Dr. John H. Gibbon, Jr., Professor of Surgery and Director of Surgical Research, Jefferson Medical College.

Pneumonectomy", by Dr. George Wright, Head, Department of Medical Research, Division of Internal Medicine, St. Luke's Hospital, Cleveland.

"Respiratory Alterations Following Total

land.

## SPECIAL COURSE—LIMITED TO 30 PHYSICIANS—SPECIAL

The Indiana State Medical Association

*offers a special course in*

### EVERYDAY PSYCHIATRY

for use by physicians in their daily practice. The course has been arranged by the Committee on Medical Education and Hospitals through the cooperation of the Staff of Norway's Foundation Hospital. The sessions will be held on four consecutive Wednesdays during the month of April beginning at 1:30 in the afternoon and adjourning at 5:30 p.m.

Registration fee is \$30.00 for the entire course, and checks should be sent to the Indiana State Medical Association. Application form is to be found on page 279 of this issue of the Journal.

The program for **Wednesday, April 7**, is as follows:

General orientation, requiring about 20 minutes, will be presented by the Director of Psychiatric Education of Norway's Foundation. Immediately thereafter Dr. John Geist, Chief-of-Staff, would discuss the patient-physician relationship as facilitating psychiatric diagnosis and therapy (30 minutes). The principles of psychiatric history taking would then be presented in 20 minutes and during the half-hour immediately thereafter an actual psychiatric history would be offered. A rest break introduced into this afternoon, as into all afternoons, at approximately hourly intervals and then the neurologic examination will be discussed and a "patient" will be examined to demonstrate its major features (30 minutes). The principles of the mental status examination (20 minutes) and the actual mental status examination findings of a patient (30 minutes). Questions and discussions (30 minutes).

#### Wednesday, April 14.

- 1:30 to 2:20 Psychopathology
- 2:30 to 3:20 Mental Mechanisms
- 3:25 to 4:25 Presentation of an actual psychiatric case illustrating a number of the mental mechanisms previously discussed.
- 4:30 to 5:30 The larger group will break into some six to eight smaller groups to allow for questions and discussion under the direction of a teacher.

#### Wednesday, April 21.

- 1:30 to 2:25 Psychosomatic Problems. Three or four discussants from the non-psychiatric specialties will present their various specialized experiences with emotional conflicts manifesting themselves through the gastro-intestinal tract, the neuro-circulatory system, and in the respiratory and dermatologic spheres.
- 2:30 to 3:25 The Psychoneuroses will be presented by three psychiatric discussants, each of whom will treat of a particular aspect of this group of emotional disorders.
- 3:30 to 4:25 Emotional Problems of Childhood (tentative).
- 4:30 to 5:30 The smaller groups will meet separately for questions and discussion.

#### Wednesday, April 28.

- 1:30 to 2:20 Presentation of Psychotherapeutic Techniques applicable to general practice.
- 2:30 to 3:20 Small groups will meet separately for questions and discussion with relation to psychotherapy for the general practitioner.
- 3:30 to 4:00 The group will again convene for a summation of the material covered in the four seminars to date.
- 4:00 to 5:00 Address by a visiting psychiatrist on a topic of interest in the practice of all general practitioners and physicians in non-psychiatric specialties.
- 5:00 to 5:30 Refreshments.
- 5:30 to 6:30 Buffet supper served in the same building where the meetings have been held.

- The course will be given by 12 diplomates of the American Board of Psychiatry and Neurology.

## CAMP SYCAMORE AT BRADFORD WOODS ESTABLISHED FOR INDIANA'S YOUNG DIABETICS

A CAMP for diabetic boys and girls, ages 8 to 15, is being established at Bradford Woods. The name of the camp is *Camp Sycamore at Bradford Woods*. The camp period will be for one month, July 5 to August 1, 1954, inclusive. Enrollment is for one month.

The camp will be primarily for Hoosier diabetic children but children from other states will not be excluded.

The camp will be administered by a joint committee of the lay and clinical groups of the Indianapolis Diabetes Association, Inc.

There will be a resident physician from one of the hospitals, dietician, laboratory technologist, and nurses on duty at all times. A member of the clinical group will be at the camp daily. A medical director will be in charge of professional management of the camp.

A subcommittee of laymen will administer financial affairs.

A Diabetic Camp Trust Fund will be set up with one or more banks, and pending the establishment of the Trust the Fletcher Trust Company has stated that they will receive and hold for the account the donations that are being received. Donations may now be sent to the Indianapolis Diabetes Association, Inc., 428 Bankers Trust Bldg., Indianapolis, Ind. The donor should specify that the donation is for the diabetic camp for children.

It is planned to have a counselor who is experienced in diabetic camps, and one junior counselor for each 4 to 6 children.

Relatively strict diabetic management, under supervision, will be carried out during the camping period. American Diabetes Association diets will be used. Referring physicians will be asked to supply the Medical Director with a medical history of the child and any recommendations that he feels are important to safeguard the child during the camping period. When the patient is sent home he will be put back on the diet and insulin dosage he used prior to the camp period.

The cost of the camp has not been definitely figured but it is hoped that the cost to the child will not be more than \$25.00 per week. It is expected that money will be donated that will defray this cost for diabetic children who would be excluded otherwise for financial reasons.

Enrollment is for the entire month. It is planned to enroll 25 children this first year and ultimately the camp is expected to accommodate 100 children.

The Bradford Woods is located on State Road 67 four miles north of Martinsville, Indiana. This land was given over to the management of Indiana University and it was specified that it be used for underprivileged children. The diabetic camp will be the first camp to use these facilities. The permanent camp facilities will be ready for use this next summer. Hospital and laboratory are provided in addition to the usual facilities found in summer camps. The cottages are winterized type.

A 100 acre lake is being constructed but will not be ready for impounding water this year.



**This is the third appearance of a new feature—a summary of Washington news—which will be airmailed from the capital on the ninth of each month.**

## THE MONTH IN WASHINGTON

Washington, D.C.—Some parts of the Eisenhower administration's broad health program are making good progress on Capitol Hill, while others are virtually standing still or bogged down in the technical complications that are always a threat to new legislation. Well ahead of the other proposals, and possibly destined for enactment, are bills to broaden the scope of the Hill-Burton hospital construction law and to liberalize income tax deductions for medical expenses.

The House Interstate and Foreign Commerce Committee, under chairmanship of Rep. Charles Wolverton (R., N.J.), wound up its long fact-finding study of voluntary health insurance plans and immediately started hearings on the Hill-Burton changes. The purpose is to amend the Hill-Burton law so that it can be used to disburse federal grants to states for construction of health facilities that do not qualify as "hospitals." The administration is anxious to stimulate the building of more nursing homes, hospitals for the chronically ill, diagnostic or treatment centers and rehabilitation facilities.

An initial appropriation of \$2 million would be authorized for surveys and planning, and \$60 million annually for three years of construction. Per capita income as well as population would be used to determine a state's share, as under the present Hill-Burton program.

At the House hearing, crowded into two days, the construction program was indorsed at least in principle by every witness, except the representative of the American Association of Nursing Homes. Because the program is limited to non-profit sponsors, members of this group could not receive grants. Their spokesman said long-term loans through the Small Business Administration would help solve their problem.

American Medical Association recommended passage of the bill, but urged that facilities for

the chronically ill and the handicapped be "part of or near a conventional hospital," and that facilities of all types be open to the entire community without discrimination, as in the present Hill-Burton law. (It is likely hearings also will be held on this legislation in the Senate.)

The House Ways and Means Committee, meanwhile, was giving its approval to a new income tax provision that would allow the deduction of medical expenses if they exceed 3% of adjusted gross income, rather than 5% under present law. The present maximum limitation would be doubled, and the deduction of travel expenses allowed where travel is prescribed by a physician. These changes—a long-time AMA goal—are embodied in the omnibus tax readjustment bill.

President Eisenhower's proposal for federal reinsurance of voluntary health plans has not been able to follow the steady course on which it first appeared to be embarked. At the House hearings, none of the spokesmen for the large organizations in the health fields—AMA, Blue Cross and Shield, American Hospital Association—was willing to indorse the plan. Like the AMA spokesmen, most of them wanted first to examine the actual administration bill, which at that time had not been introduced. From the Blue Cross, however, came a suggestion that the idea be tried out experimentally.

Spokesmen for national labor organizations expressed mixed reactions, with some maintaining that reinsurance was a poor substitute for what they believe the country really needs—national compulsory health insurance.

### —Seek Some Reductions

The administration's health budget for the next fiscal year, starting next July 1, calls for a slight overall reduction. The regular Hill-Bur-

ton program, currently operating on \$65 million, would get \$50 million (any appropriation to start the proposed expanded construction would be in addition). Relatively sharp reductions would be made in funds for venereal, tuberculosis and communicable disease control, in line with the policy of shifting this responsibility to the states. The various research institutes would receive about what they are now spending.

One of the few new items is for \$7.8 million, estimated as necessary for the extra cost of enlarging the federal program of vocational rehabilitation. Legislation authorizing the expansion is awaiting Congressional action. The administration hopes gradually to increase the number of persons rehabilitated annually from the current 60,000 to 200,000. While the program is being stepped up, one of its goals would be to induce states to increase their spending until eventually their appropriations match the federal. Like most of the President's health pro-

gram, the rehabilitation effort has the support of the AMA.

#### —Conferences Continue

Conferences between AMA officials and administration leaders are continuing. Latest sessions were with Secretary Hobby, concerning her department's legislative plans; with VA Administrator H. V. Higley, on treatment of non-service connected cases; and with Adm. Arthur W. Radford, chairman of the Joint Chiefs of Staff, Dr. Frank Berry, Assistant Defense Secretary for health and medical matters, and Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, on medical care for military dependents. Representing the AMA at one or more of the meetings were Drs. Walter B. Martin, David B. Allman, Gunnar Gundersen, Louis Orr, James C. Sargent, W. L. Crawford, George F. Lull, Ernest B. Howard and Frank E. Wilson.

Earlier, AMA representatives talked over legislation with President Eisenhower at the White House.

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#### *An Abstract:*

### THE USE OF ANTIHISTAMINE IN BLOOD TRANSFUSIONS

The authors report their experience in 1004 blood transfusions involving 1237 units of blood. Each transfusion was preceded by the injection of one-half cubic centimeter (0.5 cc) of Solution Histadyl. Their percentage of reactions of all types in this series was 2.68%. Previous transfusion experience in this same hospital had been 4 to 6% of reactions, a figure which they find compares favorably with others in the literature. There were 27 reactions, including several which might not be expected to have an allergic basis. Statistical analysis showed the figures here to be significant. The authors feel that the dosage should be increased to 20 mg. and that an additional 10 mg. of Histadyl solution should be given preceding each additional pint of blood at that transfusion.

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Bernhard, William G., M.D., Harold Grubin, M.D. and Mary V. Bryan, R.N.: Prophylactic Use of an Antihistamine in Blood Transfusions—*Journal Med. Soc., N. J.*, December, 1953. Vol. 50, pp. 542:545.

*"Then come with me in my light canoe,  
Where the sea is calm and the sky is blue."*

## STORIES OF EARLY INDIANA HISTORY PROMPT FORT WAYNE DOCTOR TO "SEE FOR HIMSELF"

**F**OR A COUPLE OF YEARS Dr. Richard C. Datzman, Fort Wayne X-ray man, spent his noon hours reading the interesting French and Indian history of the Fort Wayne area. He was particularly fascinated by the stories of the early French settlers and the Indians traveling up and down the rivers carrying their canoes overland to another stream.

Now, as a result of that noontime reading in the security of a doctors' lounge in a hospital, a restaurant or office, Dick Datzman heads for the rivers to relax.

The purchase of a canoe, tent, blanket rolls and simple cooking equipment was accomplished almost before the Datzman family realized a dream of adventure had become a quest for both knowledge and relaxation. Doctor Datzman's young son, Rickey, and his brother became interested and the trips were on.

They put their canoe on the St. Joe or St. Mary's River near Fort Wayne and travel down river. A downstream course means easier paddling for all. At each shallow area or dam they land and carry their canoe around the obstruction.

The dry weather made some streams too shallow to travel last summer. Doctor Datzman tried to go from Redkey to Marion and was forced to give up after making only three miles in one day.

The longest trip completed so far was one from Huntington to Lafayette by way of Logansport and Delphi.

For the future, Doctor Datzman has planned a trip from Fort Wayne to Toledo on the Maumee River. This is a major undertaking



Here they are—Doctor Datzman, aft, Rickey amid-ship, and Dick's brother, fore. Note all the equipment. This picture was taken just as they were leaving Chief Little Turtle's camping site at Huntington for a trip down the Wabash.

and will require about a week's canoeing following the route the Indians took from Fort Wayne to Lake Erie.

Mrs. Datzman does not participate in the actual canoe expeditions. She serves as a sort of unofficial travel agent, however. She helps with initial preparation for the jaunts, issues one order—Dick must call home each night and report that the party is safely on land—and when the mission has been accomplished and destination finally reached, she goes to pick up the party and hauls weary but happy travelers home.

To date, trips on Michigan rivers have not





This shows Doctor Datzman getting things dried out after a near disaster, along the Wabash down river from Logansport. The canoe was almost swamped in some rapids and did ship a lot of water so they stopped to dry out. It was here they put a can of beans in the fire to heat and it blew up. Now, they put holes in the cans first.

been attempted, because the "travel agent" insists it would be too far for a convenient "pick-up" service or for a rescue in case the canoe capsized and equipment was lost.

Until the spring rains have stopped, Dick Datzman will read again of the French traders and the Indian hunters and trappers who paddled their canoes from post to post, from fort to fort



Doctor Datzman puts his canoe on top of the car for the trip back up the river. The children are along for the ride.

in the early days of Indiana. Then, he will pack up again, slide his well-stocked canoe into the water, and at each opportunity set forth on a trip which will provide interest, healthful recreation and relaxation—trips which were born of the love of reading and the desire for challenging adventure.

\*The material for this story of a hobby was furnished by Dr. Richard M. Johnston, Fort Wayne, associate and friend of Doctor Datzman.

## AMEF CONTRIBUTIONS EXCEED ONE MILLION DOLLARS

Contributions to the American Medical Education Foundation during the first 11½ months of 1953 totalled \$1,047,000. The present total exceeds donations received during the entire year of 1952 by \$141,000. More than 24,500 physicians contributed \$847,361 directly to 70 of the nation's 79 approved medical schools.

Plans for the 1954 campaign were discussed at the third annual meeting of AMEF state chairmen Jan. 24 in Chicago.

# Deaths . . .

**Joseph H. Weinstein, M.D.**, former president of the Indiana State Medical Association and prominent for almost 50 years in the medical profession, died suddenly January 26 at his home in Terre Haute. He had, however, been in semiretirement for several years because of declining health.



Doctor Weinstein was a native of Illinois where he was born in 1876. He had lived in Terre Haute since childhood. His father, Dr. L. J. Weinstein, was a prominent Terre Haute physician for many years. He founded Union Hospital there in 1892.

Following his graduation from Miami Medical College in Cincinnati in 1897, Dr. Joseph Weinstein returned to Terre Haute, joining the hospital staff in 1898. In 1913 he founded the Associated Physicians' and Surgeons' Clinic, now located at 221 South Sixth Street, Terre Haute.

During World War I Doctor Weinstein served as a captain in the medical corps. He was in France in 1918-19.

Throughout his career Doctor Weinstein actively participated in medical groups with which he was affiliated. Outstanding service was given the Indiana State Medical Association. From 1907 until 1918 and again from 1922 through 1928 he served as Councilor of the Fifth Medical District; in 1910-11 he was on the Committee on Prevention of Venereal Disease; from 1922 through 1926 on the Committee on Hospital Standardization, acting as chairman in 1924; in 1932, when president-elect, he also served on the Committee on the Budget. As president of I.S.M.A., he was also a member of the Executive Committee and the Committee on the Budget in 1933. The latter post he retained in 1934 and was also a member of the Public Relations Committee from 1934-36 inclusive. In 1938 Doctor Weinstein was on the Committee on Study of Health Insurance; from 1939-44 he was a member of the Liaison Committee of the Division

of Services for Crippled Children; and in 1945-46 the Medical Economics Committee.

Although not in active practice for several years, the former I.S.M.A. president retained membership in many medical organizations and kept informed on the advances made in his profession. He was consulted frequently by fellow physicians

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**William August Bailey, M.D.**, 85, Vincennes physician since 1921, died in his home there February 1 after a long illness.

A native of Sullivan County, Doctor Bailey taught school for 13 years before entering medical school. He received his degree in 1905 from the former Bennett Medical College, Chicago.

Doctor Bailey served on the Vincennes city board of health for a number of years and was an active member of the Christian church during the 33 years he resided in Vincennes.

He was an honorary member of Knox County Medical Society, a senior member of Indiana State Medical Association and the American Medical Association.

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**Charles Culley Sutter, M.D.**, 65, died in Deaconess Hospital, Evansville, February 3. He had been ill for several months. Doctor Sutter had been a member of the staff of the Evansville State Hospital since 1949. He was a native of Evansville, a graduate in 1910 from the Indiana University School of Medicine, and served his internship at Union Hospital, Terre Haute. He practiced near Leavenworth for several years, then entered service during World War I. He was a lieutenant in the medical corps and served overseas. On his return he established a general practice in Evansville, which he retained until joining the state hospital staff.

Doctor Sutter was a former president of the Vanderburgh County Medical Society. He was

# Clinical Results\* with Banthine® Bromide

(Brand of Methantheline Bromide)

## 22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications <sup>1</sup>	Side Effects Requiring Discontinuance of Drug <sup>2</sup>	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 <sup>1</sup>			2			13
Bechgaard, Nielsen, Bang, Gruetund, Tobiasen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Walson	34	34	34 <sup>1</sup>				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16			21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3		2
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 <sup>1</sup>			18			
Maier, Meili	38	38	24			14 <sup>1</sup>	27	7	4 <sup>1</sup>				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Brodors	60	60	58		1	1	35	19	6				10	1	49 <sup>1</sup>	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 <sup>1</sup>									42
Shaken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					41 <sup>1</sup>	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES							81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



\*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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**Oliver C. Neier, M.D.**, Irvington physician since 1902, died February 6 in Methodist Hospital, Indianapolis, where he had been a patient for three weeks. Although 89 years old, Doctor Neier had attended patients until two days before he was hospitalized.

Born in Owen County, Doctor Neier received his medical degree from Rush Medical College, Chicago in 1890. He practiced in New Palestine until 1902 when he went to Irvington to assume the practice of Dr. Robert W. Long who moved to Indianapolis at that time.

Doctor Neier left Irvington for two years to practice in Gary but returned to complete 50 years of service to residents of the east section of Indianapolis. His death occurred in the same hospital where he had delivered the first baby born in that institution in 1908.

Doctor Neier was an honorary member of the Indianapolis Medical Society, senior member of

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**George A. Collett, M.D.**, 63, who was a practicing surgeon at Crawfordsville from 1926 to 1946, died suddenly in Elko, Nevada, February 3. His death occurred from a heart attack at the clinic where he had been since leaving Crawfordsville.

Doctor Collett was a native Kansan, received his degree from Rush Medical College, Chicago, and was a regent of the American College of Surgeons.

Doctor Collett was active in affairs of the Indiana State Medical Association, having served as secretary of Montgomery County Medical Society for four years, secretary of the Section on Surgery of I.S.M.A. for three years, vice-chairman of that section in 1944 and chairman in 1945. He also served on a number of standing committees and in 1946 was an alternate delegate to the American Medical Association House of Delegates.

#### **An Invitation to the General Practice Scientific Session**

All members of the Indiana State Medical Association are especially invited to attend the Sixth Annual Scientific Session of the Indiana Academy of General Practice in the Antlers Hotel, Indianapolis, on April 13, 14 and 15.

Officers of the Academy said there would be no registration fee and that an excellent program has been planned.

## *Special Subscription Course in Everyday Psychiatry*

THE PSYCHIATRIC STAFF OF NORWAYS FOUNDATION HOSPITAL, INDIANAPOLIS, WILL OFFER A SERIES OF FOUR PROGRAMS OF INTEREST TO PHYSICIANS IN GENERAL PRACTICE AND THE NON-PSYCHIATRIC SPECIALTIES

. . . The programs, approved by the Committee on Medical Education of the State Medical Association, are planned for each Wednesday afternoon in April from 1:30 to 5:30 p.m. in the auditorium of the Child Guidance Clinic of Marion County, 1949 East 11th Street, Indianapolis.

. . . Thirty physicians will be accepted as their advance registration fees of \$10.00 are received. A \$20.00 balance is payable on or before the April 7 meeting. Registration fees will be used to defray the necessary expenses.

. . . Interested physicians are encouraged to enroll by sending the enrollment blank below to the offices of The Indiana State Medical Association. Space is provided to list topics for discussion to aid programming.

Psychiatric Seminar  
Indiana State Medical Association  
1021 Hume Mansur Building  
Indianapolis 4, Indiana

Please register me for the Psychiatric Seminar. I am interested in hearing the following topics discussed:

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\_\_\_\_\_, M.D.

(\$10.00 enrollment fee payable with this registration.  
\$20.00 balance payable on or before April 7 meeting.)

# NEWS NOTES — from State and Nation

## Northern Tri-State Medical Group to Meet April 1

The 81st annual meeting of the Northern Tri-State Medical Association will be held April 1 at the Academy of Medicine, 3101 Collingwood Avenue, Toledo, Ohio. A Telecolor clinic will be held at the Academy from 5 to 6 p.m. on March 31. Subject of the telecast is "Advances in Control of Cancer of the Colon and Rectum." Registration will be from 1 until 5 o'clock on March 31.

The official meeting is scheduled to start at 9:30 on April 1 with an address of welcome by Dr. Bernhard Steinberg, president of the Northern Tri-State Medical Association, and by Dr. Frank Rawling, president of Toledo and Lucas County Academy of Medicine.

Panel discussions have been planned on allergic diseases, problems of office practice in internal medicine, clinical pathologic conference, problems in endocrinology, gastrointestinal diseases and urological diseases.

In addition to the panels, a luncheon is scheduled followed by a business meeting and a talk by Allen Saunders, cartoonist, who will speak on "The Anatomy of Humor".

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**Dr. Richard W. Wagner**, who was recently released from the Air Force, has established an office for the general practice of medicine in Huntington. Doctor Wagner received his medical degree from Indiana University School of Medicine in 1951, then served his internship in the Sacramento County Hospital, Sacramento, California. He then entered service. He was stationed in Alabama, later at the School of Aviation Medicine at Randolph Field Air Force Base, Texas, and at Bergstrom Air Force Base, Texas, before going to Korea. Doctor Wagner was discharged after a brief tour of duty as a flight surgeon of a fighter-bomber squadron in Korea.

## ISMA Committee to Attend Louisville Meeting

Members of the Committee on Industrial Health of the Indiana State Medical Association were to meet in Louisville at the Brown Hotel February 25. The meeting was scheduled in connection with the 14th Annual Congress on Industrial Health which was in session from February 23-25. Preliminary meetings were held with chairmen of state medical association committees on industrial health on February 23.

Keynote of the sessions was the partnership of industry and medicine in the maintenance of the health of the nation.

Members of the ISMA committee are E. S. Jones, Hammond, chairman; Emmett B. Lamb, A. K. Harcourt, and L. W. Spolyar, all of Indianapolis; L. S. McKeeman, Fort Wayne; and Richard C. Swan, Anderson.

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**Dr. Kenneth Craft**, Indianapolis, will be one of the speakers at the annual meeting of the American College of Allergy in Miami Beach, Florida, at the Roney Plaza Hotel April 5-10. He will speak on "Allergic Dermatitis in Ophthalmology and Otolaryngology."

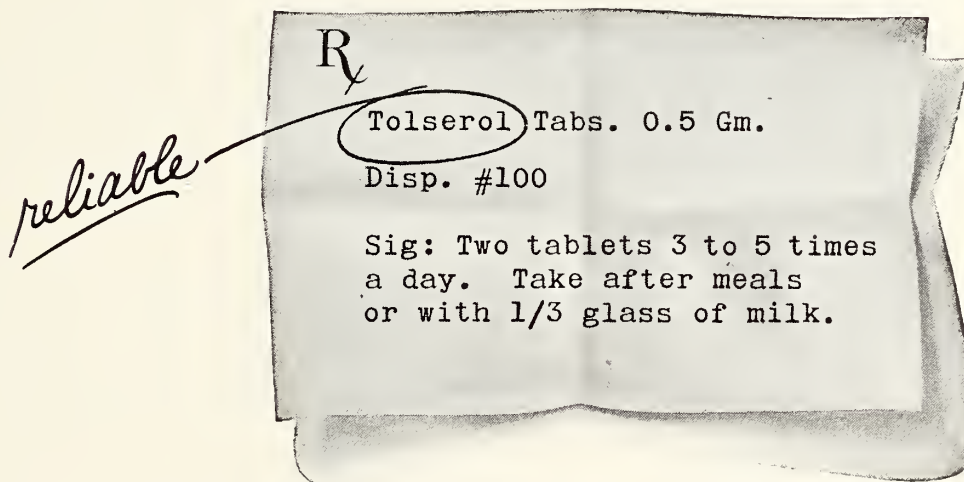
## Three Indiana Men Proctor OB-GYN Examinations

Directors of the American Board of Obstetrics and Gynecology have announced that Drs. Mahlon F. Miller, Fort Wayne, Charles F. Gillespie, Indianapolis, and Gordon C. Cook, South Bend, recently served as proctors for the February 5 written examinations given candidates for board certification.

The next examinations, Part II (oral and pathological) for all candidates will be held at the Edgewater Beach Hotel, Chicago, May 10 through 17. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance, Dr. Robert L. Faulkner, Board secretary, has announced.



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**SQUIBB**

## Plan Institute on Legal Aspects of Hospital Administration

An Institute on the Legal Aspects of Hospital Administration has been planned for April 8 and 9 at the Student Union Building, Indiana University Medical Center, Indianapolis. Sponsors are the Indiana Hospital Association, with the Indiana State Bar Association and the Indiana University Medical Center cooperating. Purpose is to stimulate awareness of the legal responsibilities and obligations of persons connected with hospital administration. All administrative, nursing, teaching and advisory personnel of Indiana hospitals are invited to attend. Registration will be at 9 o'clock Thursday morning, April 8. Fees for the two-day Institute are \$15.00 for the first registrant, \$10 for the second and all others representing the same hospital, no charge.

The program follows:

### Thursday, April 8

#### 10:00 Formal Opening

PRESIDING: B. B. McDonald, Vincennes; General Chairman, Institute on Hospital Law; Business Administrator, Good Samaritan Hospital

#### INVOCATION

WELCOME: Mrs. Dorothy G. Adams, R.N., Princeton; President Indiana Hospital Association; Administrator, Gibson General Hospital

#### 10:30 Legal Responsibilities of a Hospital Board of Trustees

CHAIRMAN AND MODERATOR: J. B. H. Martin, Indianapolis; Special Consultant in Hospital Administration, Indiana State Board of Health

*"A Hospital Trustee Looks at His Responsibility to the Community"* — Norman F. Arterburn, Vincennes; Attorney, Professor, Indiana University School of Law, Bloomington Division

*"A Hospital Trustee's Responsibility to the Hospital Administrator"* — Walter G. Ebert, Muncie; Administrator, Ball Memorial Hospital

*"A Hospital Trustee's Responsibility to the Medical Staff and to Hospital Personnel"* — Charles A. Letourneau, M.D., LLD, Chicago; Secretary, Council on Professional Practice, American Hospital Association

#### DISCUSSION PERIOD

#### 12:00 Luncheon

Cafeteria

#### 2:00 Legal Responsibility of the Hospital for the Care and Treatment of Patients

CHAIRMAN AND MODERATOR: Hon. Edwin B. Long, Bloomfield; Judge, Greene Circuit Court

*"Medical Staff Responsibilities"* — Albert Stump, Indianapolis, Attorney, Indiana Hospital Association, Indiana Medical Association, Indiana Blue Cross-Blue Shield

*"Legal Responsibilities of Nurses"* — Harold H. Bredell, Indianapolis; Attorney, Indiana Nurses' Association

*"Legal Responsibilities of Hospital Administrators"* — Herbert A. Schacht, New Castle; Administrator, Henry County Hospital

*"General Responsibilities of the Hospital to the Patient"* — Charles A. Letourneau, M.D., LLD, Chicago; Secretary, Council on Professional Practice, American Hospital Association.

#### DISCUSSION PERIOD

#### 6:30 Dinner

Banquet Room

PRESIDING: Hon. William T. Fitzgerald, Evansville; Attorney, President, Indiana State Bar Association

*"The Job of Management"* — Stanleigh B. McDonald, BS, Indianapolis; Faculty Member, Plant Management Training Department and Instructor in Reading Improvement, General Motors Institute, Flint, Michigan

### Friday, April 9

#### 9:30 Workmen's Compensation

CHAIRMAN AND MODERATOR: Hon. Lloyd D. Claycombe, Indianapolis; Judge, Marion Circuit Court

*"Analysis of the Law"* — Joseph P. Miller, Indianapolis; Chairman, Industrial Board of Indiana

*"Decisions and Trends"* — Benjamin F. Small, Indianapolis; Professor, Indiana University School of Law, Indianapolis Division

*"Insurance Carriers' Viewpoint"* — Joseph A. Wicker, Indianapolis; Hartford Accident and Indemnity Company

#### DISCUSSION PERIOD

#### 12:00 Luncheon

Cafeteria

#### 2:00 Liability and Insurance Coverage

CHAIRMAN AND MODERATOR: C. M. Warman, Indianapolis; Controller, Methodist Hospital

*"What is Necessary Fire Insurance Coverage"* — John T. Even, Chicago; Executive Assistant, W. A. Alexander & Co., Insurance

*"Public Liability and Mal-Practice Insurance Coverage"* — Don C. Hawkins, St. Paul, Minnesota; Assistant Secretary, Saint Paul-Mercury Indemnity Company

*"Hospital Admission Plans"* — Harry E. Wells, Indianapolis; Insurance Commissioner, State of Indiana

#### DISCUSSION PERIOD

#### ADJOURNMENT

The National Gastroenterological Association announces that the name of its official publication, established in 1934, has been changed from "The Review of Gastroenterology" to the "American Journal of Gastroenterology" effective with the January 1954 issue. The publication will continue to be edited by Dr. Samuel Weiss.

#### American Geriatrics Society To Meet in San Francisco

The 11th Annual Meeting of the American Geriatrics Society will be held at the Fairmont Hotel in San Francisco just preceding the meeting of the American Medical Association. The scientific sessions of the meeting will begin Thursday, June 17, and continue through Saturday morning, June 19.

Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2, California.

The meeting will be open to all members of the American Geriatrics Society and to other physicians and scientists who are interested in the field of geriatrics.

#### Health, Physical Education, Recreation Leaders to Meet

The 40th Annual Midwest meeting of the American Association for Health, Physical Education and Recreation will be held in the Claypool Hotel, Indianapolis, on March 31, April 1 and 2. George Farkas, supervisor of athletics, physical education and safety for the Indianapolis Public Schools, is convention chairman. States in the Midwest district are Indiana, Illinois, Ohio, Michigan, Wisconsin and West Virginia.

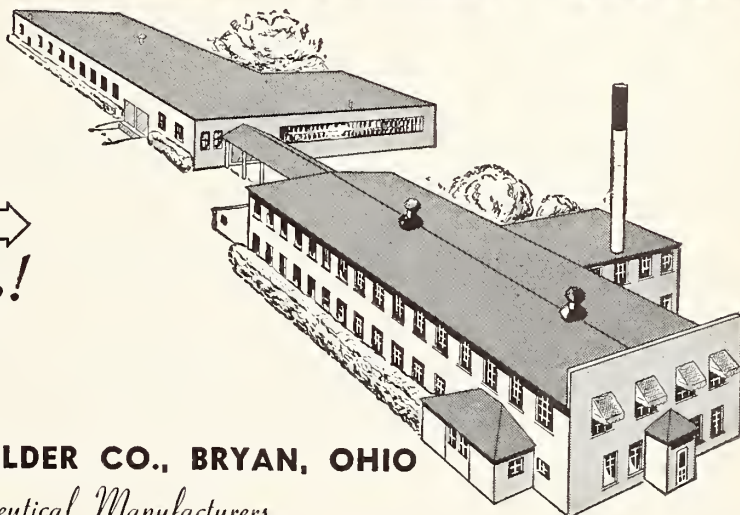
Outstanding speakers will address the general sessions and a number of section meetings are scheduled.

Recreation, health and coaching clinics will be covered during the convention.

Dr. John M. Whitehead, chief anesthetist at Methodist Hospital, Indianapolis, for 22 years, retired recently to resume private practice at his office at 1544 Roosevelt Avenue, Indianapolis.

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## Trudeau Society, Chest Physicians Hold Seminar

Thirty Indiana chest physicians attended a Symposium on Thoracic Diseases held January 20 in the Elks Club in Columbus under the joint sponsorship of the Indiana Trudeau Society and the Indiana Chapter of the American College of Chest Physicians.

Local arrangements were made by Drs. George W. Ritteman, Howard E. Rothing and David L. Adler, all of Columbus.

Physicians were welcomed by Dr. John V. Thompson, president, Indiana Trudeau Society, and Dr. James H. Stygall, vice-president, American College of Chest Physicians.

Speakers were Drs. James S. McBride, L. W. Spolyar, Donald W. Brodie, Charles J. McIntyre, Wayne Carson, Edwin R. Eaton, James H. Stygall, John V. Thompson, Russell S. Henry, Chester A. Stayton, Jr., all of Indianapolis; and Dr. J. V. Pace, New Albany.

Participating in a roundtable on "Diagnostic Problems" were Dr. Ritteman, Dr. Thompson, Dr. Stygall, Dr. Warren S. Tucker, Indianapolis, and Dr. Stayton.

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## Year-End Report on Indiana Hospital Grants Given

The Division of Hospital Facilities, FSA, reports that as of December 31, 1953, status of all Hill-Burton hospital construction in Indiana was as follows:

Completed and in operation: 25 projects at a total cost of \$14,232,021, including federal contribution of \$4,803,254 and supplying 921 additional beds.

Under construction: 18 projects at a total cost of \$29,951,720, including federal contribution of \$11,598,024 and designed to supply 1,273 additional beds.

No additional projects have been approved for Indiana.

Dr. Marvin Sandorf has moved into new ground floor quarters at 1102 Shelby street, Indianapolis, where the building has been remodeled completely. He previously had been in second floor offices at Prospect and Shelby streets.

## Army Schedules Three-Year Residency in Anesthesiology

The Army Medical Service residency program in anesthesiology will be increased in term to three years beginning July 1 to give candidates additional training, Major General George E. Armstrong, Surgeon General, announces.

The new plan announced provides for the two years of clinical training required for America Board of Anesthesiology certification and an additional year devoted to research and development training coordinated with the basic sciences in anesthesiology.

Selected Medical Corps officers will spend their first year's residency at Walter Reed Army Medical Center, Washington, D. C.; the second year will also be at Walter Reed Medical Center in the Army Medical Service Graduate School while the last year under the new program will be spent at one of four Army hospitals. The four include Brooke Army Hospital, Fort Sam Houston, Texas, Fitzsimons Army Hospital, Denver, Colorado; Letterman Army Hospital, San Francisco, California; and Walter Reed Army Medical Center, Washington.

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Ref.: J. Ind. St. Med. Assoc. 47:175 (Feb.) 1954

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50-lb. child—1 teaspoonful

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## United States Death Rate Equals Previous All-Time Low

Despite a relatively severe influenza outbreak in January and February, the United States death rate for 1953 remained at the low level of 9.6 per thousand population, according to a preliminary estimate released by the Public Health Service of the United States Department of Health, Education and Welfare.

This low rate has been achieved in only two previous years, 1950 and 1952, though the rate has been less than 10 deaths per thousand since 1948.

The Greater New York Safety Council has called a conference of sanitary experts, industrial engineers and public officials from several states to consider methods of abating the growing menace of pollution of the air and water by industrial wastes. The conference will be held at the Hotel Statler on April 8 in conjunction with the Council's 24th annual convention.

Invitations have been issued by the American Medical Association for a **regional conference** to be held in Indianapolis on March 21 under the sponsorship of the AMA's Council on Medical Service through its Committee on Federal Medical Services. Similar meetings were held during February in Denver, Portland, Omaha and Boston.

## Pan-Pacific Surgical Association Plans Congress

The Sixth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii on October 7-18, 1954. Doctors interested in attending are urged to make arrangements promptly.

An outstanding scientific program with more than 100 taking part in the scientific sessions has been planned. A program is also being planned for members of doctor's families who may wish to accompany them.

Further information may be obtained by writing F. J. Pinkerton, M.D., Director General, Pan-Pacific Surgical Association, Suite 7, Young Building, Honolulu, Hawaii.

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### American Goiter Association To Hold 1954 Meeting in Boston

A three day meeting with a program of papers and discussions dealing with the physiology and diseases of the thyroid gland will be held in Boston on April 29, 30 and May 1, 1954 by the American Goiter Association. This annual meeting of the group will be held in the Hotel Somerset.

Further details may be had by writing John C. McClintock, M.D., Corresponding and Recording Secretary, American Goiter Association, 149½ Washington Avenue, Albany, New York.

Dr. Theodore F. Schlaegel, Jr., Indiana University Medical Center, presented a paper on "The Liebmman Effect in Binocular Perception" at the meeting of the Midwest section of The Association for Research in Ophthalmology February 7 at the University of Chicago.

Doctor Schlaegel was succeeded as chairman of the Midwest section by Dr. Paul W. Miles, Washington University, St. Louis.



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## Rural Health Chairman Attends National Meeting

Dr. J. E. Dudding, Hope, chairman of the Committee on Rural Health of the Indiana State Medical Association, will attend the ninth annual National Conference on Rural Health in Dallas, Texas, March 4-6. The meeting, sponsored by the American Medical Association's Council on Rural Health will be attended by physicians, representatives of farm and community groups, and agricultural extension workers from all parts of the country.

Theme for the conference is "Let's Put More 'U' in CommUNITY". The program will stress the importance of organized community efforts in the maintenance of healthful conditions in rural areas. George D. Scarseth, Lafayette, di-

rector of research for the American Farm Research Association, is scheduled to speak on the importance of soil in nutrition.

**Dr. Hugh H. Steele** has joined the staff of the Arnett Clinic, Lafayette, where his practice will be limited to internal medicine and gastroenterology. Before coming to Indiana, Doctor Steele had been a member of the staff of the gastroenterology department at the Henry Ford Hospital, Detroit, for 10 years.

**Dr. Arthur A. Hobbs, Jr.**, head of Deaconess Hospital radiology department at Evansville, has been elected to a fellowship in the American College of Radiology. He has been head of the Evansville hospital department since 1947 when he came to Indiana from New York.

**Dr. Robert Maschmeyer** has closed his office in Shoals where he has practiced for the last six years and has gone to Logansport where he has joined the staff of the Logansport State Hospital.

**Dr. C. G. McEachern**, Fort Wayne, was the guest speaker recently at a meeting of the North-east Kiwanis Club in that city. He discussed heart surgery.

Officers elected at the recent annual meeting of Margaret Mary Hospital, Batesville, are: Dr. C. L. Lippoldt, president; Dr. George S. Row, vice-president; and Dr. L. W. Hisrich, secretary. Guest speaker at the meeting was Dr. Edward L. Ball, Cincinnati.

**Dr. E. B. Phipps**, who has been on the staff of the VA hospitals in Indianapolis and Marion for the last three years, and **Dr. John H. Grant**, recently separated from military service, are now on the staff at the Logansport State Hospital. Dr. Phipps is from Bridgeport; Dr. Grant, from Evansville.

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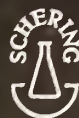


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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### THE EXECUTIVE COMMITTEE

January 23, 1954

Meeting called to order at 5:30 p.m.

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Wm. Harry Howard, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Robert Hollowell, attorney; J. A. Waggener, executive secretary; Robert J. Amick and Kenneth W. Bush, field secretaries.

Minutes of the meeting held December 13, 1953, were approved on motion of Drs. Howard and Clarke.

### Membership Report

Number of members January 22, 1954... 1,473\*  
 Number of members January 22, 1953... 1,181  
 Gain over last year... 292  
 Number of members December 31, 1953... 3,819

\* Includes 65 in military service (gratis)

40 \$10.00 members (residents and interns)

136 senior members

40 members, dues remitted by Council

AMA dues paid: 1951... 2,997; 1952... 3,569; 1953... 3,618 (includes 420 members permanently exempted in 1952)

### Headquarters Office

The field secretaries reported on their activities during the past month, pointing out that they had been explaining legislative matters and the chiropractic situation, and the availability of recordings from the library of the association.

### Treasurer's Office

The auditor's report was presented by the treasurer for the committee's review.

### Legislative Matters

#### National

The secretary informed the committee of the regional legislative conference which had been called by the A.M.A. in Chicago for February 6, and reviewed some of the points made by the President in his health message January 18.

#### Local

The secretary asked for the committee's opinion on what the position of the association should be in the forthcoming session of the state legislature on chiropractic, workman's compensation, reorganization bill for the Health Department, and consolidation

of registration boards. The committee discussed these points at length and thought the matter should be discussed further at the next meeting of the committee.

### Annual Convention, Murat Temple, Indianapolis, October, 1954

The secretary again laid the bids of Add Inc., Twiet's Display Company, and Griffith Display Company before the committee, and upon motion of Drs. Clauser and Howard, the committee voted to appoint Add Inc. of Cleveland as the official decorators for the 1954 convention.

The scientific exhibit was discussed, the secretary pointing out that thirteen booths along the wall of the exhibit hall could be made available for these exhibits at an estimated booth installation cost of \$1,110.00. By consent, it was agreed that the scientific exhibits be expanded for the 1954 meeting.

### Organization Matters

Resignation of Dr. Lall G. Montgomery, Muncie, as alternate delegate to the A.M.A. was read, accepted and passed to the Council for their action.

The secretary informed the committee that the 14-state Conference on Nursing, scheduled for Kansas City, had been cancelled.

The secretary referred to the committee the communication from the A.M.A. regarding the proposal to hold the regional 6-State Conference on Veterans Care in Indianapolis on March 21, asking who should be invited to represent Indiana at the conference. By consent it was agreed that the President, President-elect, the A.M.A. delegates, members of the Council, co-chairmen of the Legislative Committee, Veterans Committee and Liaison Committee on Veterans Care should be notified of the meeting and invited to attend.

A letter was presented to the committee from the Washington State Medical Society which was sent in answer to a request for information from that society relative to the use made of a camera at medical meetings, and upon motion of Drs. Howard and Clark the Executive Committee voted to ask the Council to appropriate sufficient funds for the purchase of two cameras for use by the field secretaries in taking pictures during their visits to county medical society meetings.

The secretary called to the attention of the committee the ruling of the American Medical Association regarding membership dues for members who have never been members of the A.M.A.

The secretary reported that as a result of inquiry made through the News Flashes that three opinions had been received regarding fee splitting,

and twenty-eight have been received opposing inclusion of physicians under Social Security.

A letter from the American Medical Association with reference to opinions of medicine regarding the relationship of the federal government with the various states was read in which the A.M.A. pointed out that the Manion Commission was desirous of having any recommendations channeled through the American Medical Association. Upon motion of Drs. Clarke and Clauser the committee voted to recommend to the Council that they make a recommendation to the effect that the Indiana State Medical Association was opposed to any additional federal aid to states.

A bulletin from the Tuberculosis Workers Association was presented to the committee in which a recommendation of this group was to be made to the National Tuberculosis Association recommending that the state association expand its operation into the field of general public health, and by consent the matter is to be referred to the Committee on Tuberculosis.

The secretary explained the proposed Hawaiian tour for members of the Indiana State Medical Association.

The request from the Hoosier State Press Association, Inc. for the purchase of space in their annual convention issue in the amount of \$40.00 was approved by consent.

By consent the secretary was authorized to change the checks for the general fund and THE JOURNAL to the same voucher type form as is being used for the petty cash fund.

#### The Journal

*Report on advertising* was accepted by consent.

#### New Business

The secretary called attention to the communication from the Fayette-Franklin County Medical Society regarding the activity of the Blue Seal Insurance Company, and the committee was informed by the president that the Blue Shield Commission was filing suit against this company.

The scientific program, compiled by the Committee on Scientific Work, was outlined by the committee.

#### Future Meetings

The secretary was instructed to attend the 40th Annual Congress on Industrial Health and the Second Conference on Management and Union Sponsored Health Centers, to be held in Louisville, Kentucky, February 23 to 25, 1954.

By consent it was agreed that Dr. J. E. Dudding, chairman of the Committee on Rural Health, should

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attend the A.M.A. Annual Rural Health Conference in Dallas, Texas, March 4 to 6, 1954.

The president discussed the proposal for a meeting of the secretaries and presidents of Illinois, Wisconsin, Michigan, Ohio, Kentucky and Indiana on Saturday, March 20, preceding the A.M.A. regional conference, and permission was granted with the recommendation that he discuss this with the Council for their approval before making definite plans.

There being no further business the committee adjourned to meet again at 11:00 a.m., on Sunday, February 21, 1954.

### ANNOUNCING A NEW SOLUTIONLESS CONTACT LENS "Fluidless Contalens"

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## INDIANA STATE MEDICAL ASSOCIATION

### THE COUNCIL

January 24, 1954.

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:40 a.m., Sunday, January 24, 1954, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Elton R. Clarke, chairman, presiding.

Roll call showed the following present:

#### Councillors:

First District -----Minor Miller, Evansville  
Second District -----Sam I. Rotman, Jasonville, alternate  
Third District -----William H. Garner, New Albany  
Fourth District -----J. E. Dudding, Hope  
Fifth District -----M. C. Topping, Terre Haute  
Sixth District -----W. U. Kennedy, New Castle  
Harry P. Ross, Richmond, alternate  
Seventh District ----Lester D. Bibler, Indianapolis  
Eighth District ----T. R. Hayes, Muncie  
Gordon B. Wilder, Anderson, alternate  
Ninth District -----Wemple Dodds, Crawfordsville  
Tenth District -----J. Robert Doty, Gary  
James P. Vye, Gary, alternate  
Eleventh District ---Elton R. Clarke, Kokomo  
Twelfth District ----Maurice Glock, Fort Wayne  
Thirteenth District --Kenneth L. Olson, South Bend  
G. O. Larson, LaPorte, alternate

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State Hospital Association*

(Additional information upon request)

Phone 678

*Officers:*

W. Harry Howard, Hammond, president  
 Walter L. Portteus, Franklin, president-elect  
 Roy V. Myers, Indianapolis, treasurer  
 Richard P. Good, Kokomo, assistant treasurer  
 Frank B. Ramsey, Indianapolis, editor of THE JOURNAL  
 James A. Waggener, executive secretary

*Executive Committee:*

James W. Denny, Indianapolis, chairman  
 E. H. Clauser, Muncie, member

*Guests:*

Cleon A. Nafe, Indianapolis, A.M.A. delegate  
 Wendell C. Stover, Boonville, A.M.A. delegate  
 William C. Wright, Fort Wayne, A.M.A. alternate  
 John M. Paris, New Albany, A.M.A. alternate  
 R. M. Hansell, Indianapolis, chairman, Committee on Convention Arrangements  
 John L. Arbogast, Indianapolis, chairman, Committee on Scientific Exhibits  
 Edwin W. Dyar, Indianapolis, chairman, Committee on Conservation of Vision  
 Carl J. Rudolph, South Bend, member, Committee on Conservation of Vision  
 Albert Stump, attorney  
 Robert Hollowell, attorney  
 Robert J. Amick, field secretary  
 Kenneth W. Bush, field secretary

*Dr. John D. VanNuy*s, dean, Indiana University School of Medicine, extended greetings to the Council, saying, "We are delighted that you would choose the Medical Center as a location for your meeting today, and I hope you will continue to use this facility. I think it means a great deal to the school to have you here and we hope you will continue to be with us."

On motion of Drs. Kennedy and Miller, the minutes of the meetings of the Council held at French Lick on October 18 and 21, 1953, were approved as printed in the December, 1953, issue of THE JOURNAL.

**Reports of Councilors**

Councilors reported that their district meetings had been scheduled as follows for the coming year:

First District -----, May -----  
 Second District -----Sullivan, June 3, 1954  
 Third District -----Jasper, May 26, 1954  
 Fourth District -----Seymour, May 5, 1954  
 Fifth District -----Terre Haute, May 19, 1954  
 Sixth District -----Shelbyville, April 28, 1954  
 Seventh District -----Indianapolis, probably May 4,

1954

Eighth District -----Muncie, -----  
 Ninth District -----Lebanon, -----  
 Tenth District -----Whiting, May 12, 1954  
 Eleventh District -----Marion, May 19, 1954  
 Twelfth District -----Columbia City, May 19, 1954  
 Thirteenth District -----Westville, November 10, 1954

**Reports of Officers**

*Dr. Wm. Harry Howard*, president, spoke of the conflict in district meeting dates and said that

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he would attend those that he could and the other officers would be present at those that he could not attend.

*Dr. Walter L. Portteus*, president-elect: "I have no report as president-elect, this being my first appearance before the Council in this particular capacity. I should, however, like to make a plea and possibly state some of my objectives in a couple of words before the coming term of my office. That is this: I think my slogan will be "unity". I would like to impress upon you gentlemen this fact—today we seem to be divided, splintered, disrupted by many outside influences. I think it is high time that we got together, not as separate, component parts, but as doctors. I would like to see a definite program instituted and I would like to make certain that we follow that sort of a program. As your president-elect, that is going to be my program."

*Dr. Roy V. Myers*, treasurer, presented the following report, compiled by George S. Olive and Company, certified public accountants:

January 20, 1954

The Council,  
 Indiana State Medical Association,  
 Indianapolis, Indiana.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1953, and the statements of income and expense and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on a cash receipts and disbursements

basis, present fairly the position of the Indiana State Medical Association at December 31, 1953, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

GEO. S. OLIVE & Co.  
Certified Public Accountants

#### Exhibit A

#### INDIANA STATE MEDICAL ASSOCIATION

##### Analysis of Increase in Assets, All Funds,

Year Ended December 31, 1953

<b>TOTAL ASSETS, DECEMBER 31, 1953—ex-</b>	
<b>hibit B</b> .....	<b>\$216,625.20</b>
<b>TOTAL ASSETS, JANUARY 1, 1953</b> .....	<b>174,728.37</b>
<b>NET INCREASE</b> .....	<b>\$ 41,896.83</b>

Arising from the following sources:

Excess of operating cash  
receipts over operating  
cash disbursements, year  
ended December 31, 1953:

General fund—exhibit C:  
Receipts --- \$129,346.05  
Disburse-  
ments --- 178,193.24

(48,847.19)

Add: Pur-  
chase of  
securities 90,000.00

\$41,152.81

The Journal of  
the Indiana  
State Medi-  
cal Associa-  
tion — ex-  
hibit D:  
Receipts --- 41,139.28  
Disburse-  
ments --- 42,337.79

(1,198.51)

Medical De-  
fense fund—  
exhibit E:  
Receipts --- 4,880.10  
Disburse-  
ments --- 2,937.57

1,942.53

**NET INCREASE** .....

**\$ 41,896.83**

#### Exhibit B

#### INDIANA STATE MEDICAL ASSOCIATION

##### State of Assets, All Funds, at December 31, 1953

##### GENERAL FUND:

Cash on deposit—Exhibit C	\$20,602.36
Petty cash fund	1,000.00
Investments:	
U. S. Treasury	
bonds	\$95,000.00
U. S. Savings	
bonds	71,000.00
	166,000.00

Total General Fund ----- \$187,602.36

##### THE JOURNAL OF THE INDI- ANA STATE MEDICAL AS- SOCIATION:

Cash on deposit—Exhibit D --- 3,761.96

##### MEDICAL DEFENSE FUND:

Cash on deposit—Exhibit E	6,260.88
Investments:	
U. S. Treasury	
bonds	5,000.00
U. S. Savings	
bonds	14,000.00
	19,000.00

Total Medical Defense fund ----- 25,260.88

**TOTAL ASSETS, ALL FUNDS—Exhibit A** \$216,625.20

#### Exhibit C

#### INDIANA STATE MEDICAL ASSOCIATION

##### Comparative Statement of Cash Receipts and Dis- bursements, Year Ended December 31, 1953, and December 31, 1952

##### GENERAL FUND

	Year Ended		
	Dec. 31, 1953	Dec. 31, 1952	Increase (Decrease)
<b>CASH BALANCE</b>			
<b>AT</b>			
<b>BEGINNING OF</b>			
<b>YEAR</b> .....	\$ 69,449.55	\$ 40,715.55	\$ 28,734.00
<b>RECEIPTS:</b>			
Membership dues	115,287.00	115,850.00	( 563.00)
Income from			
exhibits	10,700.00	14,316.00	( 3,616.00)
Interest income	2,975.05	1,507.50	1,467.55
Egbert Scholar- ship fund	-----	100.00	( 100.00)
Centennial book fund	-----	2.50	( 2.50)
Instructional courses	384.00	689.34	( 305.34)
Transferred from The Journal of the Indiana State Medical Associa- tion	-----	10,000.00	(10,000.00)
Total receipts			
—Exhibit A	129,346.05	142,465.34	(13,119.29)



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The Type-H fluoroscopic screen assembly, for example, affords complete freedom of movement, plus comfort for the patient. The exclusive Keleket screen carriage arm saves more than 25% in floor space, permits location of the unit in corner or alcove.

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**BEGINNING BALANCE PLUS CASH RECEIPTS**

	198,795.60	183,180.89	15,614.71
<b>DISBURSEMENTS:</b>			
Transfer of applicable portion of dues to The Journal of the Indiana State Medical Association exhibit D	11,199.00	11,019.00	180.00
Medical Defense fund—Exhibit E	4,387.50	4,348.75	38.75
Purchase of securities	90,000.00	35,000.00	55,000.00
Premium on purchase of securities	196.76	-----	196.76
Headquarters office expense	35,722.53	26,726.12	8,996.41
Publicity committee	779.35	906.88	( 127.53)
Public policy	4,145.39	1,608.29	2,537.10
Council	1,544.18	1,480.84	63.34
Officers	2,961.02	2,712.09	248.93
Annual session	10,426.49	13,164.98	( 2,738.49)
Standing committees	5,380.54	5,957.07	( 576.53)
Special committees	3,190.00	2,929.68	260.32
Federal insurance contributions act	273.39	239.77	33.62
Indiana unemployment compensation and excise tax	64.01	431.92	( 367.91)
Fifty-year club	422.55	245.04	177.51
Women's Auxiliary to I.S.M.A.	-----	298.77	( 298.77)
General practitioner award	1,218.00	476.04	741.96
Anti-National Health Insurance Committee	5,985.53	6,186.10	( 200.57)
Interim session	297.00	-----	297.00
Total disbursements—Exhibit A	178,193.24	113,731.34	64,461.90

**CASH BALANCE AT**

**END OF YEAR \$** 20,602.36 \$ 69,449.55 \$(48,847.19)

**Exhibit D**
**INDIANA STATE MEDICAL ASSOCIATION**
**Statement of Cash Receipts and Disbursements, Year Ended December 31, 1953**
**THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION**

<b>BALANCE, JANUARY 1, 1953</b>	---	\$ 4,960.47
<b>RECEIPTS:</b>		
Subscriptions—members—Exhibit C	-----	\$11,199.00
Subscriptions—non-members	-----	372.00
Advertising	-----	29,087.73
Collections on accounts receivable	-----	303.10
Single copy sales	-----	167.25
Electrotypes	-----	9.50
Sale of civil defense reprints	-----	.70
Total receipts—Exhibit A	-----	41,139.28
		46,099.75

**DISBURSEMENTS:**

Salaries	-----	8,877.50
Printing	-----	29,531.61
Office postage	-----	231.14
Journal postage	-----	599.96
Electrotypes	-----	1,209.06
Press clippings	-----	152.70
Office supplies	-----	270.46
Rent	-----	480.00
Electricity	-----	51.58
Telephone and telegraph	-----	233.89
Federal insurance contributions	-----	125.89
Indiana employment compensation and excise	-----	31.19
Art work	-----	95.60
Miscellaneous	-----	447.21

Total disbursements—Exhibit A ----- 42,337.79

**BALANCE, DECEMBER 31, 1953—Exhibit B** \$3,761.96

**Exhibit E**

**INDIANA STATE MEDICAL ASSOCIATION**
**Statement of Cash Receipts and Disbursements, Year Ended December 31, 1953**
**MEDICAL DEFENSE FUND**

**BALANCE, JANUARY 1, 1953**----- \$4,318.35

**RECEIPTS:**

Transfer of applicable portion of dues from the general fund—Exhibit C	-----	\$ 4,387.50
Interest income	-----	492.60
Total receipts—Exhibit A	-----	4,880.10
		9,198.45

**DISBURSEMENTS:**

Malpractice fees	-----	747.57
Attorney fees	-----	2,190.00
Total disbursements—Exhibit A	-----	2,937.57

**BALANCE, DECEMBER 31, 1953—Exhibit B** \$6,260.88

*Dr. Frank B. Ramsey*, editor of *THE JOURNAL*, asked if any of the councilors "had heard any comments about the newly established procedure of mixing the reading matter in *THE JOURNAL* with part of the advertising matter, as has been done for the past several months."

Drs. Clarke, Denny and Howard stated that they had heard a number of comments to the effect that *THE JOURNAL* format had been greatly improved within the last twelve months, that the present arrangement of the advertising gives the advertisers a much better break, and that the editor and his editorial staff should be congratulated on the fine journal they are publishing.

Drs. Cleon A. Nafe and Wendell C. Stover, A. M. A. delegates, spoke about the resolution concerning the Joint Commission on Accreditation of Hospitals which was introduced by the Indiana delegation and adopted by the A. M. A. House of Delegates at the St. Louis interim session in Decem-



ber. (See January, 1954, Journal of ISMA for full report).

#### Unfinished Business

1. *Election of two members to Indiana Inter-Professional Health Council.* On motion of Drs. Topping and Hayes the Council approved the chairman's appointment of Dr. Herman T. Combs, Evansville, and Dr. Donald E. Wood, Indianapolis, to membership on the Indiana Inter-Professional Health Council.

2. *Committee on Medical Court Testimony.* Nominations for membership on this committee to date are as follows:

First District ----- Eugene W. Austin, Evansville  
Second District ---- Virgil C. McMahan, Vincennes  
Fourth District ---- George A. May, Madison  
Fifth District ----- O. O. Alexander, Terre Haute  
Sixth District ----- Frank Green, Rushville  
Seventh District --- Ben B. Moore, Indianapolis  
Eighth District ---- Richard R. Owens, Muncie  
Tenth District ----- James F. Larrabee, Hammond  
Eleventh District -- Russell W. Lavengood, Marion  
Twelfth District --- Lynn Elston, Fort Wayne  
Thirteenth District Richard Horswell, Bristol

Third and Ninth District nominations will be made as soon as possible.

#### 1954 Annual Convention at Indianapolis

1. *Dates.* Monday, Tuesday and Wednesday, October 25, 26 and 27, 1954, approved, on motion of Drs. Kennedy and Hayes.

2. *Budget.* Dr. R. M. Hansell, chairman of the Convention Arrangements Committee, asked for a budget of \$5,000.00, and approval for holding the annual dinner-dance at the Athenaeum rather than at the Indiana Roof.

On motion of Drs. Dodds, duly seconded, the Council allowed a budget of \$5,000.00 to the Committee on Convention Arrangements, and gave the Arrangements Committee authority to decide where to hold the banquet.

3. *Scientific program.* Tentative outline, as presented by the secretary is as follows:

#### Sunday, October 24, 1954

12:00 noon. Executive Committee meeting.  
3:00 p. m. Council Meeting.  
6:30 p. m. Meeting of House of Delegates. (Dinner meeting.)

#### Monday, October 25, 1954

10:00 a. m. Annual golf tournament.  
10:00 a. m. Annual trap shoot.  
10:00 a. m. Editorial Board meeting.  
11:00 a. m. Instructional courses.  
1 to 5 p. m. Instructional courses.

6:00 p. m.

Reception and annual dinner meeting for women physicians.

Women's Auxiliary dinner.

Stag buffet dinner.

7:00 p. m.

#### Tuesday, October 26, 1954

Breakfast meetings of various groups.

Scientific movies.

General scientific meeting.

Luncheon meetings of committees, classes and fraternities.

8:30 a. m.

9:30 a. m.

Noon

2:00 p. m.

General scientific meeting.

Evening

President's night.

Address: Wm. Harry Howard, M.D., Hammond, president.

Entertainment.

#### Wednesday, October 27, 1954

Breakfast meetings of various groups.

7:30 a. m.

Final meeting of House of Delegates. (Breakfast meeting.)

Council meeting.

8:30 to 10 a. m.

Scientific movies.

10 to 10:30 a. m.

Intermission to view exhibits.

10:30 to 12 m.

General meeting on Medical-Economic and Legal Medicine.

Noon

Group luncheons.

Afternoon

Section meetings.

4:30 p. m.

Reception for members of Fifty Year Club.

6:30 p. m.

Annual dinner-dance.

4. *Scientific exhibit.* Dr. John L. Arbogast, chairman of the Committee on Scientific Exhibits, presented the following recommendations for the 1954 convention for consideration of the Council:

#### EXECUTIVE COUNCIL

#### INDIANA STATE MEDICAL ASSOCIATION

Gentlemen:

The Scientific Exhibit Committee has some definite recommendations to make for this year's meeting, on which it would like your approval, as follows:

(1) I. S. M. A. members to be encouraged to exhibit. Rather than abandoning exhibits entirely or try to get the maximum number, it is particularly desired to encourage our own members or small groups of members. (2) The stamp plan utilized at the French Lick meeting be extended to include Scientific Exhibits and again utilized this year. (3) That first, second, and third prize medals or ribbons be given for exhibits. The decision as to the prize to be made by an unknown committee of three or more, appointed by the president specifically for this purpose. (4) That the plan of appropriating money to each exhibitor



to pay the cost of the exhibit be not utilized. (5) That any ancillary services desired by the exhibitor be paid and furnished by the association, this to include table, chairs, spotlights, special decorative material, etc. (6) That every effort be made to secure the maximum publicity utilizing every volunteer for this purpose. (7) That particularly the Vanderburgh County Health Forum, and the Joint Commission on Hospital Accreditation be requested to have educational booths. (8) That a movie program not be utilized, since it would further divide and detract from meeting attendance. (9) That the Scientific Exhibits be interspersed among technical exhibits. (10) Further that a separate room not be utilized and that scientific exhibits be abandoned rather than utilize the alternative of a separate room. (11) That a budget be appropriated to cover these services.

By consent, item (8) was amended to read "That movies not be shown in the scientific exhibit."

On motion of Dr. Bibler, seconded by Drs. Duding and Olson, the Council accepted the recommendations of the Committee on Scientific Exhibits with the exception of items 2 and 9.

### Membership Problems

#### 1. 1953 Membership Report by districts:

County Society	No. M.D.'s in County	Members Dec. 31, 1953	Members Dec. 31, 1952	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
<b>1st District</b>									
Posey	15	9	11	-2	5	-	2	--	--
Vanderburgh	203	189	192	-3	2	6	13	2	3
Warrick	13	8	9	-1	1	--	5	--	--
Spencer	11	7	6	1	2	--	3	--	--
Perry	11	10	10	--	1	--	--	--	--
Gibson	25	24	25	-1	--	--	2	2	--
Pike	9	8	8	--	1	--	1	1	--
Total	287	255	261	-6	12	6	26	5	3
<b>2nd District</b>									
Knox	16	12	16	1	3	--	3	2	--
Daviess-									
Martin	29	25	26	-1	3	--	3	--	--
*Sullivan	17	17	16	1	--	1	--	1	--
*Greene	20	20	22	-2	--	--	--	--	--
*Owen-Monroe	58	56	55	1	2	1	3	1	--
Total	170	160	165	-5	8	2	9	4	--
<b>3rd District</b>									
Lawrence	29	24	24	--	1	--	4	2	--
Orange	13	13	13	--	--	--	--	1	--
*Harrison-									
Crawford	12	11	13	-2	--	--	1	1	--
Washington	8	8	6	2	--	1	1	--	--
Scott	6	4	4	--	--	--	2	--	--
*Clark	35	30	35	5	4	3	4	--	--
Floyd	37	35	32	3	1	--	1	1	--
Dubois	19	18	16	2	1	--	1	--	--
Total	159	143	133	10	7	4	14	5	--
<b>4th District</b>									
*Bartholomew-									
Brown	43	36	29	7	1	5	4	1	2
Jackson	21	18	18	--	1	1	1	1	--

County Society	No. M.D.'s in County	Members Dec. 31, 1953	Members Dec. 31, 1952	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
Decatur	17	11	12	-1	4	--	3	--	--
*Jennings	10	9	8	1	1	1	2	--	--
Ripley	16	11	12	-1	5	1	--	--	--
Jefferson-									
Switzerland	29	26	27	-1	2	1	5	--	--
*Dearborn-									
Ohio	16	15	15	--	--	--	--	--	1
Total	152	126	121	5	17	9	15	2	3

#### 5th District

Parke-									
Vermillion	28	23	24	-1	1	2	4	1	--
Putnam	18	18	19	-1	--	--	--	--	--
Vigo	126	117	113	4	4	1	6	3	3
Clay	15	11	12	-1	2	--	2	--	--
Total	187	169	168	1	7	3	12	4	3

#### 6th District

Hancock	18	15	18	-3	3	--	1	--	--
*Henry	43	41	41	--	2	2	1	1	--
*Wayne-Union	84	70	69	1	5	--	6	3	3
*Rush	18	17	13	4	--	4	1	--	--
Fayette-									
Franklin	20	17	22	-5	2	--	2	--	--
Shelby	25	22	22	--	--	--	3	--	--
Total	208	182	185	-3	12	6	14	4	3

#### 7th District

*Hendricks	18	16	17	-1	--	--	--	--	2
Marion	1037	939	896	43	56	71	76	18	15
Morgan	19	17	16	1	1	1	2	--	--
Johnson	23	21	21	--	1	1	--	1	1
Total	1097	993	950	43	58	73	78	19	18

#### 8th District

Madison	104	94	96	-2	6	--	7	2	2
*Delaware-									
Blackford	116	96	101	-5	13	3	1	1	3
Jay	19	15	17	-2	2	--	1	1	--
Randolph	27	20	21	-1	5	--	1	1	1
Total	266	225	235	-10	26	3	13	5	6

#### 9th District

*Benton	10	10	10	--	--	--	--	--	--
*Fountain-									
Warren	16	16	17	-1	--	--	2	1	--
*Tippecanoe	105	96	99	-3	7	--	5	4	--
*Montgomery	31	27	26	1	1	--	2	2	--
Clinton	28	22	24	-2	2	--	2	3	--
Tipton	15	11	11	--	--	--	4	1	--
Boone	24	19	20	-1	2	--	2	1	1
Hamilton	25	21	23	-2	1	--	3	2	1
White	11	8	4	4	1	--	--	1	1
Total	265	230	234	-4	14	--	20	15	3

#### 10th District

*Lake	346	325	324	1	14	16	29	2	1
*Porter	28	28	24	4	--	3	2	--	--
Jasper-									
Newton	22	15	17	-2	4	--	4	1	--
Total	396	368	365	3	18	19	35	3	1

County Society	No. M.D.'s in County	Members Dec. 31, 1953	Members Dec. 31, 1952	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
<b>11th District</b>									
Carroll	10	9	10	-1	1	--	1	--	--
Cass	49	38	36	2	5	1	5	1	3
Miami	23	19	19	--	3	--	--	--	1
Wabash	28	25	23	2	1	2	3	1	--
Huntington	24	22	23	-1	1	1	1	--	1
Howard	46	42	44	-2	--	--	3	2	1
Grant	61	50	50	--	7	3	3	2	--
Total	241	205	205	--	18	7	16	6	6

<b>12th District</b>									
LaGrange	9	9	8	1	--	--	--	--	--
Steuben	17	13	12	1	1	--	3	1	--
*Noble	25	24	23	1	1	1	3	--	--
DeKalb	24	21	20	1	2	1	4	--	--
Whitley	11	10	11	-1	1	--	--	--	--
*Allen	230	214	210	4	8	8	11	2	5
Wells	31	27	28	-1	2	--	2	--	--
Adams	18	14	19	-5	1	--	1	3	--
Total	365	332	331	1	16	10	24	6	5

<b>13th District</b>									
LaPorte	86	78	80	-2	5	4	3	1	--
*St. Joseph	232	205	206	-1	16	10	10	1	5
Elkhart	97	88	89	-1	2	3	7	2	--
Starke	7	7	7	--	--	1	--	--	--
*Pulaski	7	6	8	-2	1	--	--	--	--
Fulton	12	12	12	--	--	--	--	--	--
*Marshall	24	22	18	4	1	1	1	--	1
Kosciusko	18	13	14	-1	4	1	4	--	--
Total	483	431	434	-3	29	20	25	4	6

**Summary by Districts**

1st District	287	255	261	-6	12	6	26	5	3
2nd District	170	160	165	-5	8	2	9	4	--
3rd District	159	143	133	10	7	4	14	5	--
4th District	152	126	121	5	17	9	15	2	3
5th District	187	169	168	1	7	3	12	4	3
6th District	208	182	185	-3	12	6	14	4	3
7th District	1097	993	950	43	58	73	78	19	18
8th District	266	225	235	-10	26	3	13	5	6
9th District	265	230	234	-4	14	--	20	15	3
10th District	396	368	365	3	18	19	35	4	1
11th District	241	205	205	--	18	7	16	6	6
12th District	365	332	331	1	16	10	24	6	5
13th District	483	431	434	-3	29	20	25	4	6
Total	4276	3819	3787	32	242	162	301	82	57

\*Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

146 physicians received membership gratis in 1953 because of military service.

251 physicians were senior members in 1953.

2 physicians were honorary members.

125 physicians paid dues of \$10.00 in 1953 as residents and interns.

76 physicians had their dues remitted by the Council in 1953.

**2. Remission of state dues.** Dr. Garner, chairman of the Reference Committee of the Council on

Proposals for Remission of Dues, presented requests from Clay, Knox, Marion, St. Joseph, Vanderburgh and Vigo County Medical Societies for the remission of dues of seven members in these counties, all of which were approved by consent with the exception of one member in Vanderburgh County, on whom the reference committee had no information, and the member in Vigo County. On motion of Drs. Miller and Hayes, these two cases were referred back to the Committee on Remission of Dues, for further investigation, to be brought to the attention of the Council at its next meeting if the committee so desires.

**Legislative Matters**

Dr. Kennedy discussed bills pending in Congress and told of the meetings held in each county in his district with the Tenth District Congressman, which were very helpful to all concerned. He suggested that similar meetings might prove worthwhile in other districts.

Dr. Nafe spoke of the regional conferences which are being scheduled all over the United States by the Council on Medical Service of the AMA for the purpose of discussing the veterans' care program.

**Organization Matters**

**1. Medical Forums.** The Chairman called attention to the medical forums held in Vanderburgh County and in several other parts of the state which have attracted favorable attention. He suggested that the councilors pass the outline concerning these forums on to their county medical societies.

**2. Staggered committees.** Dr. Portteus suggested that the Council consider recommending to the House of Delegates that the bylaws of the association be amended to provide for the appointment of staggered terms for association committeemen. This would serve for continuity of action and efficiency of organization, as well as relieving the president of the super-human task of making approximately 250 committee appointments.

The chairman asked that the Council give this matter some thought and possibly project this suggestion into an amendment to the bylaws.

**3. Six-state conference of presidents and secretaries.** Dr. Howard spoke of the conference to be held in Indianapolis on March 20 with officers from Illinois, Wisconsin, Michigan, Ohio and Kentucky, to discuss mutual problems. At Dr. Howard's request, and upon motion of Drs. Bibler and Olson, the Council gave Dr. Howard authority to furnish refreshments for this conference.

**4. Board of Appeals.** The chairman read the following memorandum from the Board of Appeals on Patient-Physician Relations:

"Members of the Council of the Indiana State Medical Association:

"The Board of Appeals on Patient-Physician Relations at its meeting on January 10, 1954, instructed

the Executive Secretary to transmit to The Council the following actions taken by the Board:

"Inasmuch as many of the complaints coming before the Board are of a nature which makes the Board feel the services of a psychiatrist would be of benefit to the Board in handling these complaints, and desiring to expedite the procurement of this needed special adviser without waiting for action by the House of Delegates, the Board of Appeals adopted the following motions:

1. That the Board of Appeals on Patient-Physician Relations request The Council to authorize the president of the Association to temporarily appoint a psychiatrist who shall be in addition to the regular nine members of the Board and whose tenure of office shall terminate at the time of the next regular meeting of the House of Delegates. Also to permit the appointment of the psychiatrist from any Councilor district of the Association irrespective of membership of a member of the Board including a representative from the same Councilor district.
2. That the Board further request the Council to present and recommend to the next regular session of the House of Delegates the following amendment to the Bylaws of the Association:

BE IT RESOLVED, that Section 13, Chapter VIII, be amended by adding thereto the following paragraph:

In addition to the above provided membership and organization of the Board, the president of the Association shall appoint an accredited psychiatrist as a specialty member of the Board whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any Councilor district of the Association irrespective of the membership of the Board including another member from the same Councilor District. He shall have the same rights and privileges as other members of the Board and be subject to the rules, regulations and methods of procedure as approved by the Council of the Association."

"Doctor Howard, President of the Association, was present at this meeting and expressed his opinion that the Board was one of the most important facets of the public relations program of the Indiana State Medical Association and stated that he was in favor of the Association appropriating adequate funds to improve the public relations of the medical profession in Indiana.

"The chairman of the Board in thanking the President for his attendance and endorsement of the purposes of the Board, expressed his opinion that the Board had been greatly handicapped by lack of information to physicians through the I. S. M. A. Journal and News Flashes, and lack of publicity through the press and radio. He further stated that in order for the Board to function properly, effectively and fairly, the patients and physicians of Indiana should be well informed as to the services and protection provided through the Board.

"The Executive Secretary stated that all newspapers and radio stations of the state had been generous in reporting the establishment of the Board but continued publicity through the news columns is not available.

"After considerable discussion it was the consensus of opinion of the Board that a program of paid advertising should be used to inform the public of the services, protection, and scientific medical care provided by the medical profession in Indiana. It is believed that the people should be frequently reminded of what our state Association and the

county medical societies are doing about such important subjects as Around-the-Clock Medical Care, Emergency calls, Rural medical care, Maternal and Child Health, Medical care of the indigent, Medical and Hospital Care insurance, Cancer, Heart disease, Diab tes, Tuberculosis, Chronic illness, Mental Health, Venereal Disease, etc.—things that medical men are doing and lay organizations taking most of the credit for.

"The public should be told that the physicians of Indiana are contributing much of their own time and money to improve and enlarge our medical school and hospital facilities in order to provide more doctors and nurses, more hospital beds and nursing homes.

"These are just a few of the beacon lights of Indiana medicine that we could proudly present to enlighten a confused public; guiding lights now hidden under a bushel of fears, minor complaints, misinformation, and the siren calls of socialistic panaceas.

"Believing that there will be little to complain about when the public is effectively informed of the many things the Indiana State Medical Association is doing to extend adequate scientific and humanitarian medical care to all the people, the Board therefore unanimously adopted the following motion:

That the Board of Appeals on Patient-Physician Relations request the Council of the Indiana State Medical Association to appropriate adequate funds to establish and maintain an aggressive public relations program of paid advertising enlightening the people on what is being done in their behalf and alerting the profession on its responsibilities."

On motion of Drs. Miller and Garner, the Council granted the request of the Board of Appeals that the president of the Association appoint a psychiatrist to serve as a member of the Board of Appeals until the next regular meeting of the House of Delegates. (Paragraph No. 1).

On motion of Drs. Bibler and Kennedy the recommendation contained in paragraph No. 2 that Section 13, Chapter VIII, of the bylaws of the Association be amended was approved by the Council.

The request of the Board of Appeals for funds for a paid advertising campaign was discussed by Drs. Glock, Nafe, Howard, Portteus, Doty, Olson, Kennedy, Bibler and Mr. Stump, following which Dr. Bibler moved that the "Council recommend a budget of \$25,000 for this year to be provided for this committee for the purpose of favorable publicity to the medical profession." This motion was seconded by Dr. Garner.

Dr. Howard said this fund should go to the Committee on Public Relations.

Further discussion by Drs. Myers, Dodds, Nafe and Stover, following which the Council passed Dr. Bibler's motion by a vote of 9 to 4.

5. 1954 budget for the Association. On motion of Drs. Bibler and Doty, the Committee on Rural Health was voted a budget of \$2,500 for the year.

On motion of Drs. Dudding and Olson, a budget



of \$33,450.00 was voted to the Standing Committees for 1954.

On motion of Drs. Dudding and Bibler, the Special Committees of the Association were voted a total budget of \$5,950.00.

An Annual Convention budget of \$17,740.00 was approved on motion of Drs. Hayes and Myers.

#### Executive Session

The Council went into executive session to further discuss the budget.

#### New Business

1. *Interprofessional Council among allied ophthalmic professions.* The chairman read the following letter, addressed to the Indiana State Medical Association by Dr. M. Richard Harding, Indianapolis, secretary of the Section on Ophthalmology and Otolaryngology of the ISMA:

"December 28, 1953

"I would like to have the Council of the Indiana State Medical Association, at its next meeting, consider appointments to the newly formed interprofessional council (composed of representatives from ophthalmology, optometry and dispensing retail opticians). The interprofessional council is to function for better relations among the allied ophthalmic professions and the Indiana State Medical Association should have a stake in its development.

"As I understand, Medicine is to have the following representation. An ophthalmologist representing each of the following:

- (1) Ophthalmology Section of Indiana State Medical Association.
  - (2) Indiana State Academy of Ophthalmology and Otolaryngology.
  - (3) Conservation of Vision Committee of Indiana State Medical Association.
  - (4) State Committee for Prevention of Blindness.
- Also—the Chairman of Ophthalmology Department of the Indiana University School of Medicine.  
And—an M.D. representing the State Board of Health."

Drs. Carl J. Rudolph, Edwin W. Dyar and Richard P. Good discussed this matter, saying that the council is being formed at the request of the national organization, to create harmony among the groups concerned. As some conferences are to be held and an expression is desired at this time in order to go ahead with the other groups, they asked the ISMA Council for temporary approval until the matter can go through the regular channels. Then a formal study will be made by the Conservation of Vision Committee, the State Academy of Ophthalmology and Otolaryngology, and probably some of the other societies—the Indianapolis Medical Society, etc.—and a report will be made to the House of Delegates next fall as to the permanent establishment of the council, with certain limitations.

On motion of Drs. Doty and Garner the Council gave permission, or authority, for the formation of this council, and the council is to bring its recommendations before the House of Delegates at the fall meeting.

2. *Matters referred to Council by Executive Committee.*

a. Purchase of two cameras, to be used by the field secretaries, as recommended by the Executive Committee, was approved on motion of Drs. Dudding and Dodds.

b. *Manion Commission.* On motion of Drs. Bibler and Doty, the Council voted approval of the recommendation of the Executive Committee that the Indiana State Medical Association go on record opposing any additional Federal grants to any of the states.

c. *Biographical sketches of 50-year men.* The Council took no action on the suggestion of a member of the Association that biographical sketches of 50-year men be published in THE JOURNAL.

d. *Signatures on checks.* On motion of Drs. Glock and Olson, the Council approved the recommendation of the Executive Committee that the chairman of the Executive Committee be authorized to sign association checks in lieu of the chairman of the Council when the chairman of the Council is not available.

e. *Toll road route.* The following resolution from the staff of St. Catherine's Hospital, East Chicago, was tabled:

#### RESOLUTION

WHEREAS, we as physicians have a primary responsibility and interest in the welfare of those of

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**MEDICAL PROTECTIVE**  
**COMPANY**  
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 E. N. Williams, Representative  
 1177 Castle Vale Dr., Apt. 4, Tel. Highland 2649  
 If no answer, call Clay 3636

our patients hospitalized at St. Catherine's Hospital in East Chicago, and

WHEREAS, maximum quiet is recognized medically as an important requisite for any area surrounding a hospital filled with sick people, and

WHEREAS, easy and unobstructed street access to a hospital is frequently the difference between life and death in the delivery of emergency patients to the hospital and

WHEREAS, the Indiana Toll Road Commission now proposes an express highway immediately north of and adjacent to St. Catherine's Hospital, and

WHEREAS, such a highway would bring fumes, noise and interference to the efficient operation of the hospital, and

WHEREAS, an alternate route has been repeatedly suggested at a considerable distance south of the proposed route, well removed from the hospital, and

WHEREAS, as citizens of the City of East Chicago, Indiana, in addition to being physicians responsible for its medical welfare, we are distressed by the indignities the proposed route will impose upon our community in traveling through its most desirable park and residential areas, and

WHEREAS, a new residential area is already being constructed immediately north of the hospital which would be a desirable neighbor to St. Catherine's Hospital and which will be terminated if the proposed route is established,

NOW, THEREFORE, we respectfully petition the Governor of the State of Indiana, the Indiana Highway Commission, the Indiana Hospital Association, the Indiana State Medical Association, and the Indiana State Board of Health to take every possible measure to influence the Indiana Toll Road Commission to reconsider its proposed route, calling to its attention the above dangers and disadvantages, and pointing out that an alternate route is available which is acceptable not only to the citizens of the City of East Chicago, but to the medical profession as an especially concerned group.

Adopted at the regular meeting of the Medical Staff of St. Catherine's Hospital at East Chicago, Indiana, on November 24, 1953.

D. H. RUDSER, M.D.  
President

3. *Medical Education Foundation Fund.* Dr. Denny, chairman of the Committee on Medical Education and Hospitals, reported that \$97,689.59 had been forwarded to this fund to date.

4. *Physician placement program.* Dr. Dudding, chairman of the Committee on Rural Health, reported on the physician placement service of the association, saying that the great need is for rural practitioners and that the pamphlet compiled by his committee, containing pertinent information on the communities in need of physicians, had been very helpful to doctors in choosing locations. He called attention to the fact that part of his committee's budget is used to cover the expense of publishing this placement booklet and keeping it up to date.

5. *Preceptorship program.* Dr. Bibler, chairman of the Sub-committee on Preceptorships, reported

on the activities of his committee in holding a convocation with the junior and senior medical students, at which time members of his committee addressed the students. He told of the plans of the committee to entertain the juniors at the Indianapolis Athletic Club on April 12, 1954, at a dinner-dance, with Dr. Grey Dimond of the University of Kansas Medical School as the principal speaker. Dr. Bibler extended an invitation to the members of the Executive Committee and the Council to be present at this time.

6. *Suggestions for membership on Board of Directors of Mutual Medical Insurance, Inc.* On motion of Drs. Glock and Dudding, the Council approved presenting the names of the following as prospective members of the Board of Directors of Mutual Medical Insurance, Inc., in addition to those physicians whose terms expire in March, 1954:

C. Philip Fox, M.D., Washington  
Paul T. Lamey, M.D., Anderson  
Lawson J. Clark, M.D., Indianapolis  
H. R. Stimson, M.D., Gary  
George Plain, M.D., South Bend

Those whose terms expire in March 1954 are:

W. U. Kennedy, M.D., New Castle  
W. L. Portteus, M.D., Franklin  
Cleon A. Nafe, M.D., Indianapolis  
Claude S. Black, M.D., Warren  
A. P. Hauss, M.D., New Albany  
J. E. Pilcher, M.D., Indianapolis

7. *Article in answer to WOMAN'S HOME COMPANION article on cancer.* By consent the council directed that the article prepared by the chairman of the Committee on Cancer of the Indiana State Medical Association be given to the Committee on Public Relations for disposition.

8. *Spring meeting of the Council.* The Council voted to hold its spring meeting on Sunday, April 25, 1954, at the Indiana University Student Union Building, Indianapolis.

#### Elections for 1954

1. The election of an alternate delegate to the A. M. A. for the two-year term ending December 31, 1955, to replace Dr. Lall G. Montgomery, Muncie, who is a delegate to the A. M. A. because he is a section officer of the A. M. A. was deferred until the spring meeting of the Council.

2. *Chairman of the Council.* On ballot vote, Dr. Elton R. Clarke of Kokomo was re-elected chairman of the Council for 1954.

3. *Executive Committee members.* On motion of Drs. Kennedy and Glock, Drs. James W. Denny, Indianapolis, and E. H. Clauser, Muncie, were re-elected members of the Executive Committee for 1954.

There being no further business, the meeting was adjourned.

# News from the County Societies

**Boone County Medical Society** met in the Witham Memorial Hospital, Lebanon, February 2, at 6 p.m. for a dinner and business meeting. Twelve doctors attended. As in January the meeting was largely devoted to discussion and formation of a staff for Witham Memorial Hospital. Dr. William H. Spieth was chosen president of the staff for 1954. A committee was also appointed to have charge of the annual district meeting to be held at Ulen Country Club, Lebanon, on Wednesday, May 12.

A tape recording of a telephone seminar on "Pre- and Post-Operative Care" was heard by **Cass County Medical Society** members and guests at St. Joseph Hospital, Logansport, January 18. Dinner was served to 30 guests preceding the program which also included the showing of a film by Blue Cross entitled "As Sure as Tomorrow". In other action taken by the society the doctors signified their objection to being brought under the Social Security program and sent one carton of medical texts to Korea. The next meeting was scheduled for February 15 in Memorial Hospital, Logansport. Administrators of both hospitals were guests at the January meeting.

**Dearborn-Ohio and Ripley County Medical Societies** joined staff members of the Margaret-Mary Hospital, Batesville, for their annual dinner January 21 in the hospital. A guest speaker from Cincinnati was on the program.

Sixteen members of **Floyd County Medical Society** met in the New Albany Country Club January 8 at 5 o'clock for a business meeting during which committees for 1954 were appointed and business for the year discussed.

"Renal Diseases" was the subject discussed by a panel of doctors from the staff of St. Joseph's Hospital at a dinner meeting of the **Fort Wayne Medical Society** February 2 in the Chamber of Commerce.

Dr. C. J. Cooney spoke on "Recent Advances in Urologic Surgery"; Dr. J. J. Lehner, "Hematuria, Causes and Treatment"; Dr. R. M. Bolman, "The Kidney and Hypertension"; and Dr. John R. Weber, "Pediatric Renal Disease." A general discussion followed. Dr. Louis Schneider was program chairman.

Seven members of the **Fountain-Warren County Medical Society** met in the office of Dr. G. J. Himebaugh in Veedersburg for an evening meeting February 4. The group had a round-table discussion on public relations forums. The next meeting was scheduled for March 4 in Doctor Himebaugh's office.

Dr. Paul E. Humphrey, Terre Haute, was the guest speaker at the meeting of the **Greene County Medical Society** January 14 in the Freeman Greene County Hospital. He spoke on "Genitourinary Tumors." Ten members of the society attended the meeting.

At the February 11 meeting also held in the county hospital in Linton, Dr. H. W. Garton, Fort Wayne, spoke on "The Industrial Physician." Eleven members attended the dinner meeting.

Forty members of the **Grant County Medical Society** heard Dr. J. A. Campbell of the Indiana University Medical Center speak on "Newer Trends in Radiation Therapy" at their meeting January 28 in the Moose Temple, Marion. Dinner was served preceding the program. The next meeting was scheduled for February 25.

Dr. Andrew Offutt of the Indiana State Board of Health, Indianapolis, was the guest speaker at the February 9 meeting of **Hamilton County Medical Society** in Riverview Hospital, Noblesville. He presented a paper on "Tuberculosis" to 22 members who attended the dinner meeting. The March meeting was set for 6:30 p.m., March 9, in Riverview Hospital.



Dr. Thomas C. Moore, Jr., Muncie surgeon and a member of the Indiana University Medical Center staff, was the speaker at a **Henry County Medical Society** meeting January 21 in the Henry County Hospital, New Castle. He presented a paper on "Congenital Anomalies" before the 20 doctors who attended. A business meeting followed Doctor Moore's presentation during which pending Congressional legislation was discussed and the society unanimously passed a resolution to support Dr. W. U. Kennedy for the office of President-elect of the Indiana State Medical Association.

**Howard County Medical Society** held the regular monthly meeting February 2 in the Francis Hotel, Kokomo. Thirty members and six guests attended the 6:30 o'clock dinner and later heard Dr. Sprague Gardiner, Indianapolis, speak on "Lesions of the Vulva."

The March 2 meeting was also scheduled for the Francis Hotel.

New officers of **Huntington County Medical Society** conducted their first meeting January 5

in the Moose lodge hall, Huntington, at which time Dr. Donald Painter, Fort Wayne, presented a paper on "Prolonged Labor." Eighteen members and two guests attended the dinner meeting, Dr. H. F. Bonifield, former resident of the Huntington area and now living in Florida, was a special guest.

The February 2 meeting of the Huntington county doctors was held in the same place with 17 members attending. Dr. Frederick O. Mackel, Fort Wayne, spoke on "Hip Joint Diseases in Children" following which there was a discussion concerning the regional blood bank.

The March 2 meeting of the society was to be a dinner-business-scientific session in the Moose lodge.

A business meeting of the **Johnson County Medical Society** was held January 13 in Johnson County Memorial Hospital at 7:30 p.m. Seventeen members attended.

Fifteen members of Johnson County Medical Society approved legislation such as or similar to the Jenkins-Keogh Bill; approved the sponsoring of public forums by medical groups; and



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set March 10 for a dinner meeting in the Franklin Country Club which will be a joint meeting of physicians and pharmacists. This action was taken February 10 when the society met in Johnson County Memorial Hospital.

Dr. John A. Scudder, Indiana's "Physician of the Year," was honored by fellow members of **Knox County Medical Society** in the Orchard Room of the Grand Hotel, Vincennes, January 19. Twenty-six members attended the dinner and later heard Dr. D. H. Richards speak on "Old Times in Medicine."

**Lake County Medical Society** members held their annual dinner meeting January 13 in Robertsedale. Dr. William R. Troutwine, Crown Point, was installed as president. In his acceptance speech he stressed the value of being good listeners, of discussing fees in advance and of being better citizens.

"Your first responsibility is to your patients," the new president told fellow doctors, "but in troubled times like these, we should better exemplify what the words 'better Americans' mean by taking part in Community Chest, Chamber of Commerce, and youth activities."

Dr. E. Lee Strohl of St. Luke's Hospital staff, Chicago, spoke to members of **LaPorte County Medical Society** on "Abdominal Surgery in the Patient Over 70 Years of Age" at the January 21 dinner meeting in Peacock Inn, Rolling Prairie. Thirty-four members heard Doctor Strohl present an encouraging picture of the advances being made in such surgery.

Approval was given by the society to the course for overweight persons scheduled for the Purdue Extension Center.

**Lawrence County Medical Society** members met at 12:15 noon, February 10, in Dunn Memorial Hospital, Bedford, for a luncheon meeting. Sixteen members attended. Robert J. Amick, I.S.M.A. field secretary, reviewed procedures to get Medical Forum plans under way and a committee was appointed to study and draw up plans to follow through with this pro-

gram. Two films were shown through courtesy of the Upjohn Company.

A business and organizational meeting of **Madison County Medical Society** was held on January 18 in the Anderson Country Club. Dinner preceded the meeting. Thirty-nine members attended.

"Ballistocardiography" was the title of the paper given by Dr. Stanley L. Levin before 33 members of **Montgomery County Medical Society** January 21 in Culver Union Hospital, Crawfordsville.

Following the dinner and presentation of the paper, a resolution was addressed to the I.S.M.A. Council to the effect that Montgomery County Medical Society is 100 percent opposed to the extension of Social Security legislation, particularly any bill which would include medical doctors.

A special film was shown by R. J. Amick, field secretary for I.S.M.A., to 10 Morgan county

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physicians who attended the January 17 meeting of the **Morgan County Medical Society** held in the Mineral Springs Sanatorium, Martinsville. Dinner was served before the film showing and a general discussion followed.

The **Orange County Medical Society** met February 2 in the French Lick Springs Hotel at 8:30 p.m. with nine members present. Dr. C. A. Wiethoff, Seymour, spoke on "Peptic Ulcer: Surgical Importance."

A business meeting was held during which a number of specific programs were discussed.

Fourteen members of **Parke-Vermillion County Medical Society** met in the Vermillion County Hospital January 20. Dr. Don M. Mattox, Terre Haute, spoke on "Peripheral Vascular Disease," following dinner.

Dr. Hardin S. Dome, Tell City, gave a paper entitled "Reminiscences of 53 Years of Practice in the Medical Profession," at the December meeting of the **Perry County Medical**

**Society** in Cannelton. The meeting was held in the county nursing center. Members reported the veteran physician told many interesting and worthwhile incidents.

Dr. Earl Snyder, Troy, is also a 50-year member of the society.

Routine business was transacted and a film shown on Cortisone at the February 10 meeting of the **Shelby County Medical Society** in the W. S. Major Hospital, Shelbyville. The meeting was held at 5:30 p.m. The next meeting on March 10 will be held at the same time and place.

The February 9 meeting of **Vanderburgh County Medical Society** was combined with the annual Road Show of the Indiana Academy of General Practice. Afternoon and evening sessions were held in the Hotel McCurdy. Dr. Nicholas Etteldorf and Dr. Charles Joseph Deere, both of the University of Tennessee, Memphis, were scientific speakers. The regular business meeting of the Vanderburgh County Society followed the scientific program. Physi-

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cians from Indiana, Ohio and Kentucky attended.

Vigo County Medical Society installed Dr. Robert Oliphant as president for 1954 at a dinner meeting in the Pine Room of Hotel Deming, Terre Haute, January 12. Following a brief business meeting the members enjoyed a program arranged by Dr. Oliphant and Dr. Roy Pearce, vice-president.

It was also reported that Vigo County Medical Society has been organized for 108 years. Dr. Charles N. Combs, historian, disclosed that doctors of that county, however, met as a body much earlier than 1846, the year in which a record of meetings was first preserved.

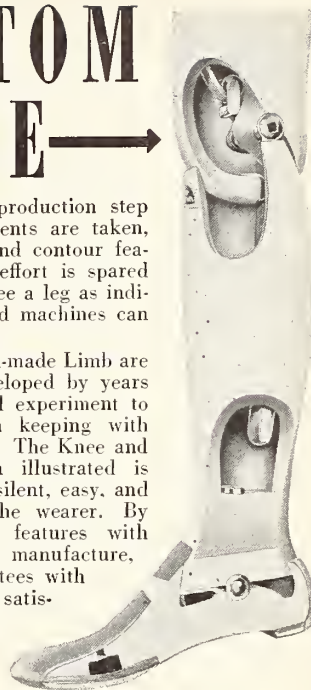
A tape recording, "Care of the Pre-School Child" was presented to nine members of White County Medical Society who attended a meeting January 12 in Holiday Inn, Monticello. The program followed dinner at 7. The next meeting of the society was scheduled for April 13 at 7 p.m. in Holiday Inn.



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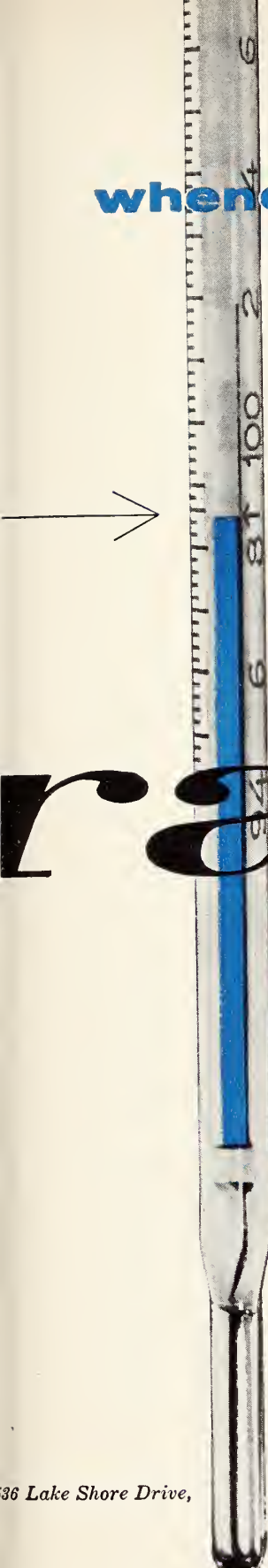
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# Medical Panorama—

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## CONNECTICUT YANKEES STAND FAST

In the *Connecticut State Medical Journal* for October, 1953, there appeared an editorial entitled "Parting of the Ways," concerned with the impending separation of Connecticut Blue Cross and Connecticut Medical Service. After outlining the origin of the latter, it stated that "Under the progressive leadership of its well-informed Board of Directors, Connecticut Medical Service began to have some justifiable ideas of its own. In no instance were these ideas narrow or reactionary, but were always shaped to make its services more useful to the public and fair and equitable to the loyal group of participating physicians, without whose help there could have been no plan."

While their set-up is different from ours in that they have "service" coverage up to a certain income level, still the general idea of a doctors' plan with the business administration conducted in cooperation with Blue Cross was similar to ours. Therefore, the sequel is of interest here, as follows, from the same editorial:

A few months ago those who were close to the affairs of the two corporations sensed that serious differences of opinion were developing. The physician members of the Board of Directors of Blue Cross and a few others promptly put forward hopeful efforts to dissolve these differences and restore and strengthen the mutually helpful working agreement that had operated successfully. But this was not to be. The issue was finally joined when Connecticut Medical Service proposed to extend its contract to cover radiological diagnostic services in physicians' offices. Because of the inclusion of a deductible provision, the actuarial estimate of the necessary additional premium to accomplish this was small. No one could deny that this would be a valuable service to subscribers and, indeed, it was urged by the Connecticut Hospital Association that Connecticut Medical Service also cover hospital outpatient radiology. Fruitless efforts were put forth by CMS to discuss the proposal with Blue Cross through the Joint Policy Committee to no avail and Blue Cross declined to aid Connecticut Medical Service in publicizing and promoting this extended contract because it involved an increase in Con-

necticut Medical Service premium and thereby might jeopardize the acceptability of the combined coverage. Soon thereafter Connecticut Medical Service was notified that the agency agreement between the two organizations would be terminated in 90 days. The Blue Cross Board of Directors was asked to reconsider this action and memoranda urging this to be done were submitted by the Board of Trustees of the Connecticut Hospital Association and the Executive Committee of the Council of the Connecticut State Medical Society but the action was sustained by the Blue Cross Board and the useful and economic alliance will terminate in the near future.

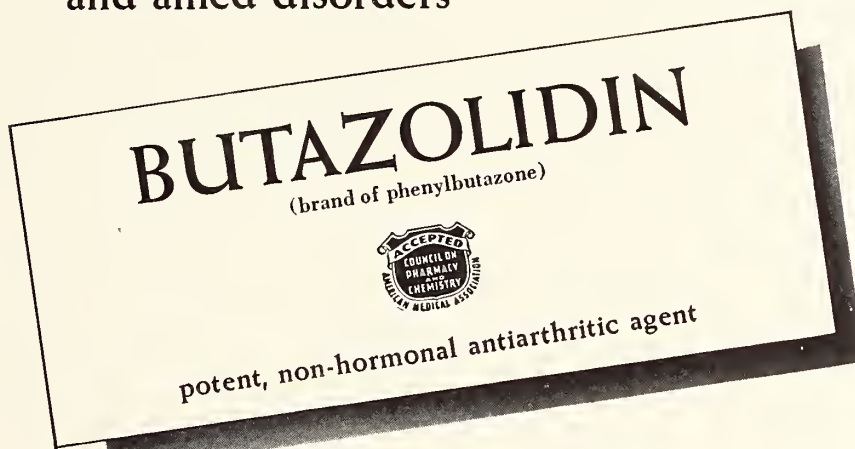
Other elements came into the controversy but in the end they were of slight importance beside the difference in the basic philosophy of the two plans. On the one hand, Connecticut Medical Service wishes to increase its value to its subscribers by wisely extending its services but on the other, Blue Cross chooses to remain as it is without added benefits. This was stated without a doubt by the president of Blue Cross when he said, "Blue Cross has intended to maintain a rate structure for the benefit of the people of Connecticut and to increase rates for the purpose of increasing benefits is not the policy of Blue Cross."

This will seem to be a short sighted policy to many people, especially in the presence of an increasing public demand for the extension of Blue Cross to cover the occasional cases requiring long term hospitalization. But it is not difficult to see why this policy does prevail if the make-up of the Blue Cross Board of Directors is examined. With the exception of the five physician members and three or four others the Board of thirty-five members consists of representatives of industrial corporations that employ large numbers of people. In many instances these corporations provide Blue Cross coverage for their employees as part of union agreements and pay the entire premium. Obviously, if the premium is raised, the cost of doing business will be increased which is a state of affairs that management understandably wishes to avoid. However, the presence of this factor makes quite unlikely a thoroughly objective appraisal of the purposes of voluntary prepayment medical and hospital plans even by the most honorable of men.

It would be idle to forecast the outcome of this Blue Cross—Connecticut Medical Service separation. Perhaps, in the light of the divergence of basic thinking it may be better for each to go its own way. In any case, the physicians of Connecticut need have no feeling of responsibility for this disturbing action or the results of it. That responsibility lies squarely in the domain of



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the Board of Directors of Blue Cross where, rightly or wrongly, the decision was made.

Since Connecticut Medical Service corresponds to our Mutual Medical Insurance, Inc., the further sequel to the above will be of equal interest. In the *Connecticut State Medical Journal* for January, 1954, there is another editorial, parts of which can be quoted to finish the story:

When Connecticut Medical Service removed its offices to a new building on December 1, it was not simply transporting desks and things a few blocks down the street. The physical move was a practical symbol of a change, but there was much more to it than that. It meant the development of autonomous policy and complete rearrangement of operative procedures.

Unless it is well understood it will be difficult to appreciate what was involved in the physical transformation. For four years CMS had been the ward and small tenant of Connecticut Hospital Service and much of its housekeeping had been done for it. Then, suddenly, it found it must seek a new house, must increase its staff three fold and do all of its own business. This has all been done and done calmly and smoothly with no interruption of normal operations or delay in services to subscribers.

Other things are yet to be realized, the months just

ahead may bring questions that have never been faced before but there is a will and experience now to face them.

The people of Connecticut have confidence in CMS and expect it to serve them; that is their only interest, they do not care where the office is. The medical profession believes in CMS, it is their child and they expressed their approval by spontaneous votes in the County Associations in October. The members of the Board of Directors, the Professional Policy Committee and the Executive Director (responsibility sleeps with the Captain) are interested and competent people who know what has to be done and will do it. Old disagreements will not be long remembered in the zeal of achievement and the satisfaction of service. It is truly "Part of Connecticut," vigorous and self reliant.

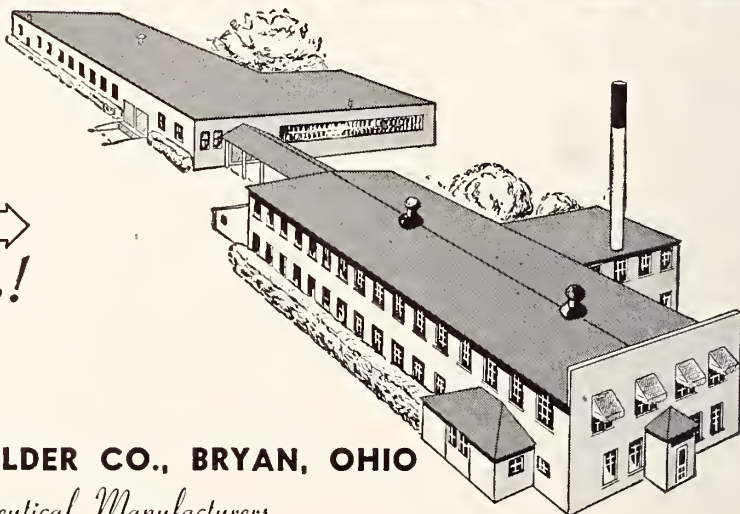
Connecticut Yankees have long had the reputation of being shrewd, hard-headed and rugged individualists, and it appears that Yankee doctors combine some of these characteristics with their humanitarianism, to good purpose. More than this,—they stick together on the job in matters pertaining to the profession as a group. We salute them, while at the same time we hope for no rift between Blue Cross and Blue Shield in Indiana.

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## ALL OBLIGATED PHYSICIANS DUE FOR ACTIVE SERVICE BY JULY 1, 1955

During the next fiscal year, starting next July 1, the Defense Department expects that all hospital interns and residents obligated for military service will have to be called to active duty. However, according to Assistant Secretary Berry, the demand may not be as heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. For the men facing almost inevitable calls, Dr. Berry urges hospitals to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. This will remove them from the jurisdiction of their draft boards, and allow Defense Department to request delay in call for men the Department recommends for additional training.

This information is contained in a statement from Dr. Berry, in charge of medical and health matters for the Department of Defense. Dr. Berry also presented the results of a poll of medical school deans, who were requested to ask fourth year students the following questions: 1. If given free choice, which service would you prefer? 2. Do you prefer to serve your time immediately following internship? 3. Or following internship and one year of hospital training? 4. Or following full residency training? The results showed 27 percent of the students preferred the Army, 37 percent the Navy and 36 per-

cent the Air Force. 39 percent preferred service immediately following internship, 15 percent preferred it after two years of hospital training and 46 percent preferred military duty after full residency training.

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## RESERVE PHYSICIANS PROMOTED TO BRIGADIER GENERAL BY ARMY

The recent promotion of four Medical Corps reserve officers to the rank of brigadier general, U. S. Army Reserve, has been announced by the Department of the Army.

The four officers, all of whom command reserve hospital centers and are diplomates of American Specialty Boards, are: Brig. Gen. Alexander M. Marble, Boston, Massachusetts, commanding general of the 804th Hospital Center; Brig. Gen. Perrin H. Long, New York, New York, commanding general of the 818th Hospital Center; Brig. Gen. Harold G. Scheie, Philadelphia, Pennsylvania, commanding general of the 31st Hospital Center; and Brig. Gen. Frank E. Wilson, Washington, D. C., commanding general of the 805th Hospital Center.

General Marble, a member of the American Board of Internal Medicine and a specialist in diabetes, is a professor of medicine at the Harvard University College of Medicine. In addition, he is serving as a consultant in internal medicine to Murphy Army Hospital, Waltham, Massachusetts. He was graduated from the Harvard University College of Medicine in 1927 and served his internship at the Johns Hopkins Hospital, Baltimore, and a residency at the Massachusetts General Hospital. During World War II he served in the Army Medical Corps as chief of Medical Service at the Station Hospital, Camp Edwards, Massachusetts, and Harmon General Hospital, Longview, Texas. He also acted as medical consultant to the 6th and 8th Service Commands.

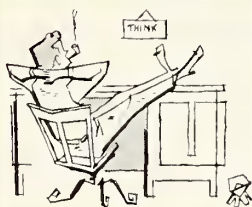
Also a member of the American Board of Internal Medicine is General Long, who is professor of medicine at the Medical College of the State of New York. Prior to accepting his professorship in New York, General Long

was professor of Preventive Medicine at Johns Hopkins University School of Medicine, Baltimore, where he also was commanding officer of reserve medical group. General Long will be remembered as one of two civilian physicians flown to Pearl Harbor as consultants in the mass treatment of casualties resulting from the Japanese attack there. Later, he entered the Army Medical Corps and became chief consultant in medicine of the Mediterranean Theater of Operations. He is at present serving as a consultant to the Army Surgeon General, the Veterans Administration and the United States Public Health Service. He is a graduate of the University of Michigan School of Medicine.

General Scheie, a member of the American Board of Ophthalmology, is a professor at the School of Medicine of the University of Pennsylvania, Philadelphia. He was graduated from the University of Minnesota College of Medicine in 1935 and received the degree of Doctor of Science in Ophthalmology from the Graduate School of Medicine of the University of Pennsylvania in 1940. During World War II, General Scheie was chief ophthalmologist of the 20th General Hospital and chief consultant in his specialty in the CBI theater.

General Wilson, director of the Washington office of the American Medical Association, is certified by the American Board of Preventive Medicine and Public Health. He was graduated from the University of Tennessee College of Medicine in 1933 and received the degree of Master of Public Health from the University of North Carolina in 1947. During World War II he served on active duty with the Army Medical Corps. His primary assignment was in the European Theater of Operations as Executive Officer of the 807th Hospital Center. He was separated from active service in the rank of colonel.

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## Wanted: PHYSICIANS LOCATIONS

As part of the Physician Placement Service of the Indiana State Medical Association a continuous program was undertaken some months ago to attempt to bring prospecting physicians and the communities needing doctors together. At intervals lists of doctors inquiring about opportunities in Indiana and lists of cities and towns seeking physicians have been published in *THE JOURNAL* and also mailed individually to the sponsor in communities which have sought assistance.

Copies of the placement booklet have been mailed to each doctor who has made inquiry. Through this two-way service a number of placements have been made in Indiana.

Listed below are new communities seeking doctors and new doctors asking for information about Indiana openings for physicians.

### Locations:

ACTON—Marion county; population 1,000; contact Mr. Jack Poe, Acton, Indiana.

ZIONSVILLE—Boone county; population 1,633; contact Dr. L. S. Bailey, Zionsville.

MANCHESTER—Dearborn county; population 300; contact Mr. Stanley J. Duncan, R.F.D. 2, Aurora, Indiana.

ETNA GREEN—Kosciusko county; population 500; contact Jene R. Lindsey, Cashier, The Etna Bank, Etna Green, Indiana.

### Physicians:

D. E. Harrison, M.D., (General surgery), 1028 W. Third Street, Dubuque, Iowa.

John R. Crist, M.D., (General practice), 36 Hopeland, Dayton, Ohio.

Franklin R. Shaft, M.D., (Internal medicine, cardiology), New England Center Hospital, Boston 11, Mass.

Frank R. Sendra, M.D., (General practice), 9759 S. Claremont Avenue, Chicago 43, Illinois.

W. L. Martin, M.D., (General practice), 335 Merriweather Road, Grosse Pointe 30, Mich.

Richard E. Lahr, M.D., (General practice), The Toledo Hospital, North Cove Blvd., Toledo 6, Ohio.

Norman L. Marxen, M.D., (General surgery), Lakewood Hospital, 14519 Detroit Avenue, Lakewood 7, Ohio.

Joseph W. Kramarczyk, M.D., (General practice), 3909 Lewis Avenue, Erie, Pennsylvania.

John G. Davis, M.D., (General practice), 1029 Castle Shannon Blvd., Pittsburgh 34, Pa.

Frank J. Ewers, Jr., M.D., (General practice), 414 N. Meridian Drive, Apt. C, Forrestal Village, North Chicago, Ill.

Ross B. Sommer, M.D., (Internal medicine), 411 Harvard St., Norfolk, Va.

Albert A. Fisk, M.D., (Internal medicine), 7960 Richard Road, Cleveland 29, Ohio.

Carlos M. Aquino Sosa, M.D., (Associate or group practice), Lima Memorial Hospital, Lima, Ohio.

Lester I. Nienhuis, M.D., (General surgery), 3207 Groveland Lane, Houston 19, Texas.

Andrew Lee Megarity, Jr., M.D., (Industrial), 3459 Dury, Apt. 1, Cincinnati, Ohio.

Anton N. Lethin, Jr., M.D. (Pediatrics), Yale Univ. Sch. of Medicine, 333 Cedar Street, New Haven 11, Conn.

E. A. Scollin, M.D., (Associate in surgery), 1328 S. Broadway, Leavenworth, Kansas.

Charles N. Tarkington, M.D., (Group practice), 3616 Castleman Ave., St. Louis 10, Missouri.

Herbert Frank, M.D., (Internal medicine), Dakota Clinic, 702 First Avenue South, Fargo, North Dakota.

James J. Pampush, M.D., (Internal medicine), 1807 Warren Avenue, Seattle 9, Washington.

Arthur I. Holleb, M.D., (Surgery), 345 E. 68th, New York 21, N. Y.

Evan R. Williams, M.D., (General practice), 300 S. Weinbach, Evansville, Indiana.

Sam Packer, M.D. (Surgery), 10704 Shaker Blvd. Cleveland, Ohio.

Lloyd J. Lemmen M.D., (Neurosurgery), Tokyo Army Hospital, 8059th A. U., A/P.O. 1052, c/o Postmaster, San Francisco, Calif.

Allen W. Wittchow, M.D., (Ophthalmology),



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# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Editor's Note: The following editorial was published in the Kansas City Star on February 6. On February 12, the same newspaper published the following answer by Edward J. McCormick, M.D., President, American Medical Association, in their editorial page column "Speaking the Public Mind." THE JOURNAL herewith presents both editorial views.

## THE INEPT A.M.A.

We like doctors. We are very much against socialized medicine, just as they are. For the devotion to research and the great progress in medicine and extending the life span, we can't pay high enough tribute. But, frankly, we can't refrain from remarking that the American Medical association (A. M. A.) has about the most stupid and impossible public relations imaginable. It probably isn't intended. But whoever is setting up as a spokesman, supposedly for the doctors of the nation, is certainly inept, to put it in the most charitable fashion.

The public is getting the impression the A. M. A. is against almost everything under the sun. We don't believe doctors, as a rule, feel that way at all. Just recently the A. M. A. has taken on the veterans organizations by campaigning against admittance to government hospitals of veterans with nonservice connected disabilities. It is feared this might open the door to socialized medicine. We are not quarreling so much with the soundness of the protest as the general effect flowing from it.

Most of the veterans' groups are sore as a boil at the A. M. A. and all needlessly. If there is an abuse it's one in which the veterans' groups should be consulted, with the Veterans administration itself leading the cleanup if there is to be one.

President Eisenhower has even more recently put before the country a broad program extending not only social security but the health activities of the government to reach more millions. It explicitly emphasizes that it stops short of socialized medicine and that completely. It entails more government aid for hospitals and clinics, possible government reinsurance of private group hospitalization plans, especially those on the border line, to include the more needy.

The acclaim with which the A. M. A. spokesman received this program was so silent as to be almost

vociferous in its implication. Even friendly members of Congress are asking just where the A. M. A. stands on this general welfare program and if it really represents the thinking of the average doctor. We don't believe it does. The height of absurdity has almost been reached when it has been suggested the A. M. A. favored the Bricker amendment to the Constitution, because the door might be opened to socialized medicine by some international agreement flowing from the United Nations. Or maybe the A. M. A. reached its "agin" peak when it opposed federal aid to medical schools and that when this whole country is in desperate need of doctors.

The sure and certain way to get socialized medicine is for the vocal leadership of the medical profession to become chronic "aginnners." Just being against something doesn't stop it. We are going to progress in medicine and care of the people's health one way or another. It can and should be done short of socialized medicine and within the bounds of our private enterprise system. Doctors should take the lead. If it doesn't come that way, we will have socialized medicine, sure as fate. The whisky and brewery interests opposed everything until we got the experiment in prohibition. Big business used to see a bogey man behind every move that represented progress until big business itself became the whipping boy of the politician and the demagogue. Business began to show sense. The bigger the business usually the harder the work on the problem of public relations now. It has changed the climate.

We are ready to believe that the impression being left by the A. M. A. spokesman comes from inexperience in the field of public relations more than intent. But there should be a quick shift from "agin everything" to lifting the banner high and spearheading the drive for carrying better health programs to more millions with the A. M. A. taking the lead. That's the way to stop socialized medicine. And we believe this reflects the real opinion of the great majority of our fine folks of medicine.

—The Kansas City Star

## Speaking the Public Mind A.M.A. NOT JUST "AGIN," ITS PRESIDENT SAYS—

The American Medical association has been under attack for many years by the proponents of government medicine. This attack has centered on



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two points: (1) that the A. M. A. does not represent the true thinking of the rank and file doctors and (2) that the A. M. A. is a "standpat" organization which is "agin" all health progress. Both of these charges are false, but both were repeated in a Kansas City Star editorial on February 6.

Let me emphasize that the A. M. A. is a democratic organization. Its policies are decided by majority vote of a 190-man house of delegates, representing every state in the union and all the specialties and general practice. Missouri doctors not only are represented in this house, but have a member serving on the A. M. A. board of trustees.

In support of the second point The Kansas City Star characterized as "needless" the A. M. A.'s stand against the admittance of non-service-connected cases to veterans hospitals. Particularly, it said this stand shouldn't have been taken without consultation with the VA and veterans' groups. The truth is that the A. M. A. has been meeting with these groups for over twenty years without solution of the problem. The veterans groups want more and more hospitals for veterans.

Doctors feel that sufficient VA hospitals have been constructed to care for all service-connected cases and see no reason why American taxpayers should finance the medical care of veterans whose illness has absolutely no connection with service. According to the VA's own figures, such cases now total 65 percent of the daily patient load in VA hospitals.

#### **For All the People**

Doctors are not against veterans; they are for all the people. We believe tax funds should be used to help build community hospitals, chronic disease centers and other medical facilities open to all the citizens of a community, including veterans. This is what President Eisenhower has proposed and we strongly endorse it. This stand does not make the A. M. A. popular with veterans groups, but we believe it has the support of the majority of citizens and will result in better care for all in the long run.

The editorial also criticized the A. M. A. for its supposed silence regarding President Eisenhower's health program. This is what the A. M. A. said in a nation-wide press release on January 24:

"The board is pleased to find so many of the ideas and principles for which the A. M. A. has striven for so many years. The board endorses the general objectives of the President to extend needed facilities, to promote further research, to increase coverage under voluntary health insurance and to rehabilitate the disabled."

The A. M. A. has reserved judgment on the proposal for federal reinsurance of voluntary health insurance because to date this is just a vague idea. No specific bill has been presented. There is also serious question in the private

insurance industry as to whether any such program is necessary since companies already reinsure each other.

#### **On Health Deductions**

The A. M. A. has, however, taken a strong stand in favor of allowing all medical bills, including health insurance premiums, to be deducted from taxable income. This would require no additional federal bureaucracy, and would help those who need help most—the people who have suffered a serious illness or injury within a given year.

The A. M. A. supports the principle of the Bricker amendment because there are at the present time several international agreements under study by the State department which would institute government medicine. These could be adopted by a two-thirds vote of the senators who happened to be sitting in the Senate chamber at any time and would supersede all previous decisions to the contrary. We favor an amendment which would insist that any treaty or executive agreement involving domestic law must be passed by both houses of Congress, as all our internal laws now are passed.

In a blanket manner, the editorial criticized the A. M. A.'s stand on federal aid to medical schools, implying A. M. A. was against training more doctors. The association is strongly in favor of expansion of our medical schools, and has demonstrated so repeatedly. The only question is how this can best be done.

#### **Against School Subsidies**

A. M. A. has opposed yearly subsidies to medical schools because of the danger of federal control of education. It has, however, supported one-time federal grants for the construction of medical school facilities, a proposal similar in nature to the Hill-Burton hospital construction act, which the A. M. A. has always endorsed. The American Medical association is spending thousands of dollars annually through its council on medical education and hospitals to encourage the improvement and expansion of medical schools. In addition, it has established a nonprofit foundation to raise money for medical schools which has contributed \$2,830,000 in the last four years.

The editorial seemed to imply that doctors public relations would be better if we were never "agin" anything. We do not believe our responsibility is to pose as Pollyannas. We believe our responsibility is to be honest with the people. This means pointing out dangers and opposing unsound measures as well as pushing many projects for improvement in the health field. While we say "bravo" many times, it is necessary to say "no" in a very definite man-



## NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.<sup>1</sup> It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.<sup>2</sup> In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: *M. Clin. North America* 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 225.

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ner on occasion. After all, seven out of the Ten Commandments begin with "Thou shalt not . . ."

We agree with The Kansas City Star that the A. M. A. should lift the banner high and spearhead the drive to carry better health to more millions. That is our aim. However, in the constant bombardment under which we have been working, it is often necessary to shore up our fortifications as well as lead the attack. Our job would be easier if we doctors were not subjected to the kind of uninformed heckling which appeared in The Kansas City Star editorial.

EDWARD J. MCCORMICK, M.D.

President, American Medical Association.

—The Kansas City Star

#### MEDICAL CARE

The American Medical Association has expressed the view to the House commerce committee that a distorted view has been given of the nation's medical needs to promote government controlled medical care. Dr. Walter B. Martin, president-elect of the association, said that a federal reserve board survey had disclosed last year that 80 per cent of all American families reported no medical debts at all and that less than 3 per cent needed help to pay their doctor bills.

He stated that the only group requiring outside help in obtaining the basic necessities of life, which comprehend many things besides medical care, is the frankly indigent, and that medical care of these people is a local and state responsibility. Almost 93 million Americans, Dr. Martin said, were able to afford some form of hospital benefit insurance.

The doctor also mentioned that while the cost of living has increased almost 91 per cent from the 1935-1939 period and average weekly wages have increased 165 per cent, medical costs are up only 65½ per cent and physicians' fees rose only 48 per cent.

The showing is substantial that only a small minority of Americans require help in paying their doctor bills, and that they are paying much less proportionately for medical care than for other basic needs. No case has been made for any program of large scale federal intervention, but as long as politicians see the chance of votes in offering people something for nothing, just so long will we keep on hearing about the need for government action.

—The Chicago Tribune

#### MEDICAL SCIENCE AND THE PRESS

News media and the medical profession have at least one thing in common.

That is a ready recognition that both have been negligent in their duties of keeping the American

public properly informed on matters of medical science.

Much has been accomplished during the past 10 years towards remedying this situation. It has been an era of trial and error.

Medics have learned that an informed public is a more rational one. Patients who have advance knowledge concerning their ills do not shy away from the physician's office. Nor do they go leaping off rooftops in a frenzied fear of the "unknown."

\* \* \*

Reporters of medical science have learned not to go off the deep end on new scientific findings, incomplete experiments, etc., without first making a thorough check of the facts.

The veil of secrecy and superstition which has cloaked the sciences has been lifted. Those in the field of journalism who report on medical science have been educated to a degree of specialization. They have more than a passive knowledge on their subject matter.

\* \* \*

In general, we in the Calumet area in our own small way have seen a progressive working relationship between medics and the press. Much of this credit goes to the local medical associations.

Hospitals have come to recognize that the community has a healthy interest in the ills of its members. Realization of our neighbor's problem is desirable. Common knowledge on most any matter, be it even unpleasant, lifts the clouds of loneliness and despair.

The day of "yellow journalism" in the handling of medical news is coming to a close. Another disease has been stamped out. Not all medical advancement has come from the lab.

Gary Post-Tribune

#### MEDICAL FADS

Defining a fad as "an unreasonable and usually passing enthusiasm for an object or procedure" John O. Hildebrand, M.D., in an address on WSBT, The Tribune's radio station, has made some thought-provoking statements on "fads in medicine." As a radio speaker sponsored by the St. Joseph County Medical society Dr. Hildebrand did not state or intimate that doctors themselves are faddists where treatment devices and processes are concerned. It is definitely reassuring that "the caution of the

medical profession tends to lessen the dangers" of faddism.

The medical profession, especially in its organization form on the pattern of the American Medical Association, is unreasonably criticized at times for its members' refusal to become enthusiastic about some much-publicized "cancer cures," among other things. Medical fads, as Dr. Hildebrand remarked, are not invariably bad but the "dangers" have more practical importance than the decidedly limited benefits. "Doctors are or ought to be," was one of Dr. Hildebrand's most impressive statements, "the people's watch dogs as to medical fads."

His reminder that the state department of health and the federal pure food and drug act also provide protection was impressive. Now, as usual, medical faddism is alluring for many people. Such things as "miracle drugs" and synthetic vitamins have value but the benefits are more limited than many laymen realize. Members of the medical profession should not be subjected to public pressure to endorse or use things carrying the faddist stamp.

—South Bend Tribune

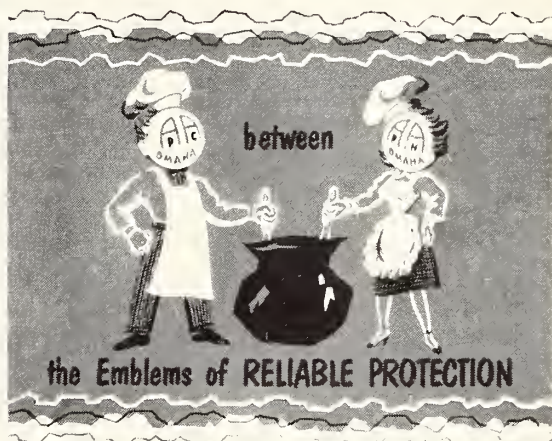
#### National Physical Medicine, Rehabilitation Session Set

The thirty-second annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11 inclusive in the Hotel Statler, Washington, D. C. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the annual scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

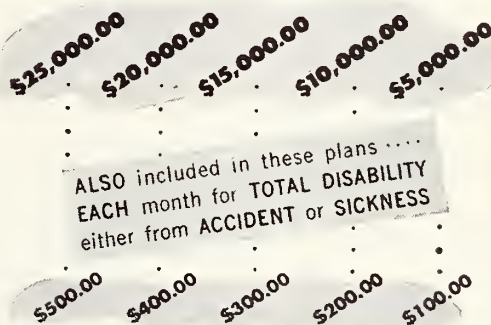
Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

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## TOTAL ADRENALECTOMY FOR ADVANCED BREAST CARCINOMA A Preliminary Report

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**B**ILATERAL TOTAL ADRENALECTOMY is the newest advocated method of hormone manipulation for the palliative management of advanced carcinoma of the breast. Its specific physiological effect is not understood though its influence must be exerted from removal of the androgens and estrogens normally produced in them. Hormone manipulation in itself is not new. Schinzinger<sup>1</sup> and also Beatson<sup>2</sup>, reporting independently in 1889 and 1896, respectively, suggested castration for advanced breast carcinoma. Lett<sup>3</sup> in 1905 reported a total of 99 cases of inoperable carcinoma of the breast treated by castration and stated that 36% of the patients had had either distinct or marked improvement. It is interesting to note that he, nevertheless, recommended the operation be dis-

continued for he felt that it had fallen into disrepute. It is of further interest that like so many other developments in clinical medicine, it was only after these first clinical observations had been made, that the problem was taken to the laboratory. Lathrop and Loeb<sup>4</sup> reported in 1916 that castration of young female mice decreased the incidence in later life of spontaneous breast carcinoma. The influence of the sex hormones was emphasized further by Lacassagne<sup>5</sup> who found that carcinoma of the breast could be induced in mice by the injection of massive doses of estrogens; and by Nathanson and Andervont<sup>6</sup> who reported an inhibiting effect on experimental breast cancer by the injection of testosterone propionate.

Both estrogens and androgens have been used clinically to a great degree in the last 15 years for advanced breast carcinoma. In order to instill some degree of order into this complex

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problem, the American Medical Association through its Committee on Research, embarked on a cooperative study of these substances, reports of which have been made periodically since then<sup>7</sup>.

Although Lathrop and Loeb had pointed out the possible effect of the adrenal gland on the development of carcinoma of the breast in the castrated animal, clinical studies of the influence of the adrenals on various types of hormone controlled neoplasms were not initiated until Huggins and Scott<sup>8</sup> used adrenalectomy for the control of advanced carcinoma of the prostate. Their early patients could not be controlled properly, but when cortisone became available, the procedure was used again for the treatment of not only prostatic cancer but also advanced breast cancer. Huggins and Dao<sup>9</sup> have written that 10 of 25 such women treated by adrenalectomy alone, and 10 of 25 managed by combined adrenalectomy and oophorectomy, had regression of the disease of a measurable magnitude.

Total adrenalectomy without concomitant oophorectomy has been performed on a total of 14 women with advanced breast cancer at the Indiana University Medical Center since March 1, 1953. Ten of the patients have had a sufficiently long postoperative period for their results to be evaluated and form the basis of this report. The patients chosen for this procedure were generally selected on the basis of extensiveness of the disease, as well as continued progression of the metastases. A few patients with advanced breast cancer were not accepted; some, for example, because it was felt that they could not be relied upon to take cortisone regularly after the operation, others because of advanced age, and still others were refused when it was believed that such methods of therapy as irradiation and estrogen or androgen administration would be more suitable. Poor physical condition was not necessarily a criterion for refusal to offer the operation. Brief summaries of the histories of 10 are as follows:

**Case No. 1 (N. O.)** The patient was a 60 year old woman with advanced recurrent carcinoma of the breast. There was extensive ulcerating disease of the left anterior chest wall, bilateral supraclavicular lymphadenopathy, marked edema of the left arm, a large fixed mass in the right breast and bilateral axillary lymph node

enlargement. Her menopause had occurred at the age of 54. An adrenalectomy was performed on March 18, 1953. The postoperative course was uneventful. The procedure had no observed effect on the course of the disease and the patient died on August 3, 1953.

**Case No. 2 (M. K.)** This 36 year old patient complained of unsteadiness in her gait. There was metastatic carcinoma in the base of the skull where the right 5th, 6th, 8th and 9th cranial nerves were involved and in the cervical, dorsal and lumbar vertebrae where metastatic disease was demonstrated by x-ray. The patient had received a sterilizing dose of x-ray in November, 1952. The adrenalectomy was performed on May 11, 1953. A complete neurological examination was repeated on May 18, 1953, and showed definite improvement of the cranial nerves as compared with the examination on April 29, 1953. The improvement lasted, however, for a period of only three more weeks. Progression of the disease then became evident and it moved inexorably forward causing her death on December 12, 1953, in spite of a bilateral oophorectomy and androgen administration as additional therapy.

**Case No. 3 (E. S.)** This 53 year old woman was admitted to the hospital complaining of progressive enlargement of the abdomen. She had marked ascites, a left pleural effusion, shortness of breath, swelling of the ankles and subcutaneous nodules in the anterior chest wall. She had not menstruated since the time of a hysterectomy 10 years prior to admission. After repeated paracenteses and a regime of supportive therapy, a right adrenalectomy was performed on May 18, 1953. The patient tolerated this procedure very poorly, and the left side was not done on that date. She recovered remarkably well, however, and after further preparation, the left adrenal was removed on May 27. These procedures did not control the peritoneal fluid, and on July 2, 1953, radioactive colloidal gold was instilled into the peritoneal cavity. The patient had had significant subjective improvement prior to this date and the radioactive material controlled the ascitic fluid. The patient remained in excellent health for several months and was able to resume normal activities, even to the point of taking hikes and driving her own car. Late in December, 1953, she began to deteriorate rapidly. The ascitic fluid recurred and was not



affected by additional radioactive gold. She died on January 22, 1954.

**Case No. 4** (E. N.) This 64 year old woman was admitted to the hospital with a small nodule in the skin of the left anterior chest wall, edema of the left arm, an infraclavicular mass on the left, swelling of the left arm and a nodule in the right axilla. Her menopause had occurred at the age of 50. She had had previous radiation therapy to the mediastinum, as well as estrogen therapy which had caused diminution in the infraclavicular lymph nodes. However, in the few months before admission these lymph nodes had begun to enlarge. Preoperatively 500 ccs. of clear yellow fluid were removed from the left pleural effusion. The adrenalectomy was performed on June 1, 1953. One month later the left infraclavicular lymphadenopathy had disappeared and it has remained quiescent to the date of writing. There has been no further pleural fluid. There is little change in the edema of the left arm. The right axillary lymph node continued to enlarge and was removed surgically several months ago.

**Case No. 5** (E. P.) The patient was a 69 year old woman who was admitted to the hospital on June 1, 1953. Her previous therapy had consisted of a left radical mastectomy in August, 1949, and intrapleural radioactive colloidal gold in June, 1952, for treatment of a pleural effusion. She had also had a course of stilbestrol therapy. She was admitted to the hospital because of significant loss of weight and recurrent tumor in the suprasternal notch. Her menopause had occurred between 18 and 22 years previously. The adrenalectomy was done on June 15, 1953. Her postoperative course was uneventful, except that late in July, 1953, she complained of nausea, unusual perspiration and physical disturbances. She exhibited adrenal insufficiency and was readmitted to the hospital for regulation of her cortisone therapy. She was discharged five days later. She is now in good health without orthopnea or exertional dyspnea.

**Case No. 6** (E. W.) The patient was a 66 year old white woman who was admitted to the hospital on June 15, 1953, with an extensive untreated carcinoma of the right breast. There was edema of the right arm, right supraclavicular and axillary lymphadenopathy, and a large

ulcerating tumor of the right breast. She had lost 24 lbs. in weight in two years. Her menopause had occurred at the age of 36. The adrenalectomy was performed on June 16, 1953, and her postoperative convalescence was uneventful. By August 14, 1953, it was noted that the ulcerated area in the skin of the breast was healing, and this healing was completed by September 18. The lymph nodes in the right axilla and supraclavicular region completely disappeared. In spite of these changes, the major tumor in the breast began to enlarge and it was thought wise to do a simple mastectomy for her. This operation was performed on January 18, 1954.

**Case No. 7** (N. E.) This patient was a 39 year old woman who complained of loss of weight. There were numerous recurrent intracutaneous nodules in the skin of the left chest wall in the mastectomy scar, and there was a fixed mass in the upper outer quadrant of the right breast, 4 cms. in diameter. She had been sterilized by x-ray six months before her present hospital admission. The adrenalectomy was done on July 3, 1953. The patient immediately began to have both objective and subjective improvement. On August 21, 1953, the mass in the right breast had completely disappeared and the nodules on the left anterior chest wall had faded extensively. On January 22, 1954, it was believed in all likelihood the tumor in the skin, as well as in the right breast, was beginning to recur.

**Case No. 8** (M. C.) This patient was a 65 year old woman who complained of nodules of the skin of the chest wall and pain in the neck and the left leg. She had had radiation therapy to a left supraclavicular mass and had also been given hormone therapy of an undisclosed type. There was a mass in the left mastectomy scar, measuring 3 cms., a nodule in the left lateral chest region, and x-ray evidence of metastatic disease in the left femur, left superior pubic ramus, and skull. The menopause had occurred at the age of 41. The adrenalectomy was performed on August 20, 1953. The patient had subjective improvement but when last seen in the Tumor Clinic on January 29, 1954, there had been no essential change in the size of the mass on the chest wall.

**Case No. 9** (H. J.) The patient was a 49 year old woman admitted to the hospital with

extensive recurrence of carcinoma of the breast. She had had radioactive colloidal gold for the control of a right pleural effusion and extensive x-ray therapy for recurrent carcinoma in the chest wall. Her menopause had occurred at the age of 41. There was extensive carcinoma in the skin and subcutaneous tissues of the chest wall, chiefly in the right anterior and right lateral chest. There were lymph nodes in the right supraclavicular region and in the left axilla and there was a right pleural effusion. The adrenalectomy was performed on September 21, 1953, after several thoracenteses had removed the fluid from the pleural cavity. It had no effect on the course of the disease. The patient began to deteriorate rapidly in October and she died on November 1, 1953.

**Case No. 10 (E. H.)** This 51 year old woman was admitted to the hospital on September 9, 1953. She had been followed in this institution since December, 1950, when a left radical mastectomy was performed because of a carcinoma. X-rays in May, 1953, had showed extensive bone metastases, and when they were repeated on September 11, 1953, they showed metastatic disease in the skull, spine, pelvis, and ribs, as well as probably lymphangitic disease in the right lung. There was no recurrent disease in the skin of the chest or in the regional lymph nodes. This process essentially was one of involvement of the bones. Her menopause had occurred in 1950. The adrenalectomy was performed on September 21, 1953. Her postoperative course was uncomplicated. She was discharged and seen for follow-up on October 14, 1953, but she died unexpectedly on October 30, 1953. Her family physician believed that the cause of death was a coronary thrombosis.

*Preoperative and Postoperative Management.* The purpose of adrenalectomy is to remove the estrogen and androgen production of the adrenal cortex in an attempt to alter favorably the course of breast carcinoma. Adrenalectomy also withdraws from the patient's physiological system the corticosteroid hormones concerned with protein, carbohydrate, fat, water, and mineral metabolism which are essential to life. For this reason, cortisone with or without desoxycorticosterone must be given after adrenalectomy.

The patient is weighed several times before surgery and several blood, pressure determina-

tions are made to establish a base level of the values. We have followed a plan for preoperative hormone administration similar to that of Huggins and Bergenstal<sup>10</sup>. One hundred milligrams of cortisone acetate are administered intramuscularly 24 hours, 12 hours, and 2 hours before surgery. Five milligrams of desoxycorticosterone are administered intramuscularly 12 hours and 2 hours before surgery. Usually 5 grams of sodium chloride are given during the evening meal preceding the day of surgery. The steroid management after surgery has usually included 50 mg. of cortisone acetate intramuscularly every 4 hours for the day of surgery, 50 mg. every 6 hours, the day after surgery and 50 mg. every 8 hours the second day after surgery. Five milligrams of desoxycorticosterone are also given intramuscularly once daily on the first and second postoperative days. Usually on the third postoperative day the desoxycorticosterone is discontinued and cortisone is administered orally instead of intramuscularly using 25 mg. every 6 hours on this day. The cortisone is gradually reduced during the next 4 to 5 days until a maintenance level is obtained which has varied from 25 mg. to 62.5 mg. daily. The majority of cases have been maintained either on 12.5 mg. every 8 hours or 12.5 mg. at 7:00 a.m., 12.5 mg. at 2:00 p.m. and 25 mg. at bedtime. The serum electrolytes including sodium, potassium and chloride are usually determined one or more times during the postoperative period as a guide to parenteral fluid administration.

At the time of discharge the patients are instructed to weigh themselves daily and if their weight varies 5 or 6 pounds, especially over a period of only a few days, they are instructed to consult their physician. Following discharge from the hospital they have been seen every three to four weeks for evaluation. The course of their carcinoma is checked, and they are observed for edema formation and hypotension. The blood pressure should be taken in both the supine and upright position because an orthostatic hypotension is characteristic of adrenal cortical insufficiency. The patients are carefully instructed about the importance of taking their cortisone. If they have an illness with associated vomiting, they are told to consult their physician for consideration of parenteral cortisone administration. Patients are instructed that infections,



fever, and certain emotional disturbances may increase their requirements for cortisone. During excessively hot weather it may be necessary to add desoxycorticosterone to the management and the usual dose is 2.5 mg. intramuscularly once daily. A few patients may have manifestations of orthostatic hypotension when cortisone is given alone. This condition may be corrected by the daily use of desoxycorticosterone.

We have had two cases who have demonstrated significant adrenal cortical insufficiency. In one patient, case No. 5, it was precipitated by the hot weather and in another, case No. 3, it was apparently caused by the instillation of radioactive gold into the abdominal cavity which caused nausea and considerable vomiting. Both cases responded to intravenous saline and alteration in cortisone and desoxycorticosterone dosage.

*Operative Management.* The bilateral lumbar approach with removal of the 12th ribs has been employed in all cases. As the plan developed for the use of the procedure, it was thought that the single bilateral subcostal abdominal incision would be preferable since it would obviate the two incisions and would permit operation without turning the patients between stages. However, considerable dissection on pathological material convinced us that, in spite of the fact that each adrenal could be visualized rather adequately through the abdominal incision, exposure difficulties were unnecessarily great by this approach and the bilateral lumbar incisions were accepted, even though it meant turning the patient at the conclusion of one side, reparation of the skin, and redraping. Infusions of 5% glucose and blood transfusions were always used during the operation. Blood pressure variations during the procedure required the employment of 1-norepinephrine on seven patients during the operation itself, and on six in the postoperative phase. A solution of 4 mg. of levophed in 1000 ccs. of 5% glucose in distilled water was employed. Cyclopropane is thought by some to be incompatible with 1-norepinephrine and was not used as an anesthetic agent. As soon as the postoperative blood pressure stabilized the patients were mobilized and most of them were ready for discharge in 7 to 10 days.

The adrenal glands in 4 of the 10 patients

showed metastatic carcinoma. They were cases 3, 6, 7 and 8.

*Results.* Five patients showed objective improvement, and it was of a striking degree in four. They were cases 3, 4, 6 and 7. Two patients deteriorated steadily in spite of the procedure, and there was no change in two. One patient died too early for adequate evaluation.

Two of the remaining four patients mentioned, but whose case histories have not yet been summarized, may also be undergoing some improvement, but it is too early to estimate adequately their response to this procedure. Unfortunately, it is not possible to anticipate preoperatively the response of the patient and there are no measures available that will, at this writing, help with the selection of patients. Pearson and associates<sup>11</sup> have suggested that variations in calcium excretion that are synchronized with the patient's menstrual period will indicate what tumors are under estrogen control and will suggest what patients should be adrenalectomized. Additional data will be needed to evaluate completely this test because calcium excretion may vary considerably under a variety of conditions in addition to menstruation. Perhaps in the future an index can be developed from their studies, or perhaps from the unpublished studies of others, that will be of importance in this respect. There is little question, however, that the procedure should be considered seriously for patients for whom surgery, x-ray and other forms of hormone therapy have been ineffectual in the control of progressive metastatic disease. It seems at this time that removal of the adrenal glands in patients who have advanced recurrent breast carcinoma will assume a place in the hormone control of this disease.

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*An Abstract:*

## REGIONAL ENTERITIS

Our knowledge of regional enteritis as a clinical entity dates back only about 20 years. Little is known of its etiology except most of the cases occur in young male adults, and involve any part of the intestinal tract but the terminal ileum is the most frequent site of the lesion. The pathology and clinical manifestations parallel each other. In the acute stage the bowel is swollen, congested and hyperemic, and often covered by a fibrinous exudate. In the subacute stage there is marked thickening of the bowel wall with proliferation of fibrous tissue. In the chronic stages marked fibrous hyperplasia occurs with ulceration of the mucosa, abscesses and fistulae.

In the acute stage the symptoms frequently simulate those of appendicitis which is the usual preoperative diagnosis. As the disease progresses loss of weight, diarrhea, intra abdominal abscesses and fistulae appear. Vomiting and signs of acute intestinal obstruction are the frequent clinical picture of the later stage of the disease.

The treatment of this disease is resection of the involved bowel. If the diagnosis is made preoperatively the patient may be prepared for extensive bowel surgery. However, as so frequently happens, the diagnosis is made at laparotomy in the acute stage and bowel resection should be deferred for a subsequent operation. In the acute stage an occasional case will spontaneously subside. It appears that there are no drugs which affect the course of the disease.

# RENAL CELL CARCINOMA

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**C**ARCINOMA OF THE RENAL PARENCHYMA has long been termed hypernephroma; this term will probably continue to enjoy wide and popular usage. Few, or perhaps no, renal neoplasms are truly derived from adrenal rests, as this term would indicate. A more modern and correct nomenclature of these lesions is derived from the renal tubule cells from which these tumors are thought to spring. The discussion to follow will deal with these neoplasms and experiences in the management of 44 cases over a 14 year period at the Indiana University Medical Center. Many were not suitable for definite curative surgery. Often metastases precluded any other than palliative management. Fundamental in the care of renal neoplasms is the truism that all renal tumors are to be considered malignant until proven otherwise.

## ETIOLOGY

The etiology of renal cell carcinoma is unknown. There is reliable data to show that malignant change in benign renal adenomata can and does occur. Few adenomata are of sufficient size and strategically located to originate clinical symptoms and signs allowing clinical diagnosis. Thus there is a paucity of pathologic data to show this change. That adenomata and carcinomata are derived from renal tubule cells is generally accepted today; however, the mechanism setting off oncosis is unknown.

## INCIDENCE

The majority of renal parenchymal carcinomata occur in the fifth, sixth, and seventh decades, although many occur as early as the third.

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Their occurrence in the very young is rare, there being only four such cases listed in the American Tumor Registry. The youngest patient having this lesion in our series was 27 years of age, who is alive and well 13 years later. The oldest patient was 82. The median age was 58 and the mean age was 62 years. The occurrences in males outnumber those in females and right renal tumors outnumber those on the left in large series reported in the literature. In our experience, however, the occurrence has been equally divided as to sex and side.

## PATHOLOGY

Renal cell carcinoma grossly occurs as a well-encapsulated yellowish solid mass in the renal parenchyma. Usually the tumor will occupy or replace one or the other renal pole. Tumor size may assume prodigious proportions, filling an entire upper and lower quadrant of the abdomen. The occurrence of large dilated veins over the surface of the neoplasm, external to the renal capsule, is common and often indicates occlusion of normal venous channels by tumor tissue inducing such collateral venous distention. Extension of tumor through its dense fibrous capsule occurs occasionally with invasion of contiguous structures, resulting in fixation of the mass. Histologically the tumor mass may present two distinct pictures.<sup>1</sup> The clear cell variety displays isometrically placed nuclei, the cells arranging themselves in cords and strands with coarse supporting trabeculae. The granular cell type is characterized by eccentrically placed nuclei with sparsely supported tubules and papillary formations. The latter is often attributed the poorer prognosis. These cell types may occur in the same tumor. Metastases progress by way of the blood stream in all but a few incidences. Lung, bone, liver, regional lymph nodes, spleen, and

adrenal bear the brunt of metastases in that order of frequency.<sup>2</sup> Fifty-six percent of our series had metastasis on admission to the Indiana University Medical Center. Expanding osteolytic metastasis to bone in the middle decades of life is most likely to be renal in origin. Nineteen of our cases fell into this category. Pulsatile metastases with bruit are not uncommon. These may be mistaken for arteriovenous aneurysms, particularly in the extremities. Curiously enough, renal cell carcinoma may establish a solitary metastasis amenable to secondary surgery. Alexander and Haight<sup>3</sup>, reporting 24 cases undergoing pulmonary resection for solitary metastasis, found 6 cases arising from renal cell carcinoma. Late metastasis is not rare. The literature is replete with recurrences in distant sites ten years or more postnephrectomy. Thus a five year survival rate in this disease is not significant.

### CLINICAL CHARACTERISTICS

The symptoms of hematuria, pain, and mass are well known to be the triad indicative of renal cell carcinoma. In our series of 44 cases, this triad was the presenting symptom-sign complex in 55% of the cases. Hematuria was the presenting symptom in 60% of our cases. It is interesting to note that only one case of painful hematuria was found, the remaining cases being of the painless type. This is unusual when one realizes that 79% of the cases were found to have a palpable abdomino-flank mass. Hematuria presents itself when the tumor has invaded the mucosa of the pelvis or eroded the vasculature of the kidney. Abeshouse and Weinberg<sup>4</sup> in their review of malignant kidney tumors feel that no prognostic significance can be assigned to the duration of symptoms, but agree that early evaluation of the patient who presents hematuria is of the utmost importance.

It is utterly shocking to report that the average duration from the onset of hematuria until diagnosis was made in our series of cases was 6.4 months, the earliest case being of two weeks' duration and the longest case 15 years. As far as we can discern, the fault lies with the procrastinating patient and the laxity of the physician to evaluate completely this ominous sign. *We firmly believe that hematuria, either macroscopic or microscopic, is a definite challenge to the physician to rule out malignancy of the genitourinary tract, and feel further that every case*

*of hematuria deserves urologic investigation unless a definite cause can be established without it.*

Abdomino-flank mass was the next most common symptom in our patients and was found present in 79% (35 cases). Herman<sup>5</sup> feels that 60-80% of cases sustaining surgery have a palpable mass while other investigators report a lower percent. In our review, 25 cases (60%) going to surgery had a palpable abdomino-flank mass.

Pain was not a common presenting system in our series. Olson<sup>6</sup> in his review found the incidence of pain to be between 33-36%. We agree with Abeshouse and Weinberg who found an incidence of 25% to have presenting pain. Pain in renal cell carcinoma is of two types: 1. The colicky type of pain which is caused by presence of blood clots passing down the ureter, initiating urinary blockage; and 2. The dull achy, constant pain due to stretching of the renal capsule by the expanding tumor mass from within.

Extra-urinary complaints such as weight loss and malaise were found in 24 cases (54%). Concomitant alimentary symptoms of nausea, vomiting, and constipation were noted in 61% of our cases. One patient was admitted with the typical history of chronic cholecystitis and suggestive right upper quadrant mass. X-ray examination showed a poorly functioning gallbladder. However, during the preoperative evaluation, intravenous pyelography disclosed a suggestive deformity of the right kidney which proved to be renal cell carcinoma at operation. We describe this case in an effort to point out that not infrequently renal neoplasms may mask their presence with gastrointestinal symptoms. Urinary symptoms of dysuria, frequency, and nocturia were reported in 20 cases and were associated with lesions of the prostate gland or pyuria due to bladder infections coincidentally present. Hypertension was considered as any pressure greater than 140/100, and was found in 7 cases (15%). The significance of this finding is not definitely established. Pulmonary complaints of chest pain, cough, and shortness of breath were found in 17 cases; 16 of these showed pulmonary metastases by x-ray examination. Symptoms referable to the lower extremities were apparent in 7 of our series. Their complaints were of leg pain, edema, and/or fracture. All of these patients were found to have metastatic bone disease. Edema of the



lower extremities may be an ominous sign representing stasis due to vena caval obstruction, either by compression or invasion by frank tumor. The febrile state in the absence of renal infection reported by some investigators was not a common finding in our series. However, it is a well known fact that alarming temperature elevation can be encountered in these people, indicating necrosis and absorption of tumor tissue.

Laboratory data often of significance are the finding of anemia and, of course, hematuria. Of our series 34% disclosed an admitting hemoglobin below 10 gm %. Surprisingly enough, however, only 30% of our patients had microscopic hematuria on admission. This is interesting when, as stated above, 60% had hematuria as the presenting symptom. Therefore, be not misled by complete cessation of renal bleeding. Too often a false sense of security has been derived from apparent cessation of hematuria postponing establishment of the cause of this serious sign. Papanicolaou smear of urine sediment is of little practical value in this lesion, in contradistinction to that of papillary carcinoma of the urothelium.

The roentgenogram will usually establish the diagnosis. Pyelograms may be inconclusive, but in the vast majority of cases they are diagnostic of a space-filling lesion in the kidney. Furthermore, we believe it is the responsibility of the clinician to survey the chest and suspicious skeletal areas for recognition of metastasis. Reliable differentiation between tumor and cysts of the kidney can only be made at surgery. Lumbar aortography visualizes the arterial renal tree and may give strongly suggestive evidence of tumor when the "puddling phenomenon" of dye in the tumor vascular sinuses is seen.

## MANAGEMENT

Surgical extirpation is the only curative treatment for this neoplasm and is the accepted therapy by most physicians. In our opinion, roentgen therapy is of little if any value, although long-term controls have been mentioned with its use. We do use x-ray in the palliative control of metastatic pain. The authors feel that the thoraco-abdominal<sup>7</sup>, trans-abdominal approaches, and the dorsolumbar incision recommended by Nagamatsu<sup>8</sup>, offer the best access for

the removal of the affected kidney. These incisions allow the operator wide exposure so that he may deal with the renal pedicle under direct vision, search for metastases in the abdominal cavity, and limit the possibility of injuring adjacent viscera. It is very important that one handle the pedicle, whenever possible, under direct vision, minimizing the danger of displacing tumor cells from the venous components of the mass into the general circulation. The renal artery should be ligated primarily. The renal vein should then be milked free of all contents, beginning from its insertion into the vena cava, then ligated. We feel that inspection of the vein should then be carried out with resection of the vena cava, if extension of the tumor mass is strategically located to allow such vascular management. It is imperative that if the vena cava must be ligated, it be done below the opposite renal vein. The kidney and perirenal fat should be removed *en bloc*. Ureterectomy is unnecessary. Downway implantation of renal cell carcinoma into the lower urinary tract is rare. Surgery for solitary metastases may be a life-giving procedure and should be carried out whenever practicable. One of our patients developed a solitary lung metastasis one year after nephrectomy. Lobectomy was done and the patient lived an additional two years before succumbing to her disease.

Operative mortality has been reported by Abeshouse and Weinberg as 8.5%. In our series of 17 nephrectomies, there were no operative deaths.

## PROGNOSIS

The ultimate prognosis of the patient suffering from renal cell carcinoma is not enviable. Deming<sup>9</sup> reported in a series of 51 cases a five year survival of 19.5% and a ten year survival of 14.6%. These findings are in agreement with many other investigators. McDonald<sup>10</sup>, however, claims 40% five year survival in a large series at the Mayo Clinic.

Follow-up of our operative patients has been successful in all cases. Four are known to be alive and well ten years or more post-nephrectomy (23.5%). The same number represent a five year survival. Three others are alive and well less than five years post-nephrectomy. The average length of life of those of our series unsuited for nephrectomy was less than 6



**Figure 1. RETROGRADE PYELOGRAM, case no. XL 172680.** 40 year old white male with right flank mass of 7 months' duration and no hematuria. Retrograde pyelogram shows massive defect of lower pole, right kidney, with displacement of ureter to midline.

months. Smith and Shoemaker<sup>11</sup>, in their study of unoperated renal cell carcinoma, found that 60% died within the first year and 73% by the close of the second year.

## SUMMARY

Forty-four cases of renal cell carcinoma are analyzed. Seventeen (38%) proved to be operable, and 4 (23.5%) of these survived 10 years or longer. Emphasis is placed upon the early diagnosis of the cause of hematuria. We feel that an increase in survival rate can be accomplished with careful technical removal of the kidney, keeping in mind the tendency of venous invasion by this tumor. Only thus can improvement in the management of renal cell carcinoma be realized, in the light of our present knowledge of therapy.

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**Figure 2. GROSS SPECIMEN, case no. XL 172680** Gross specimen of pyelogram above. Note large round areas of capsulated tumor on cut section. Clinically mass was large but freely movable.

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# ANALYSIS COMPILED OF INDIANA CANCER DEATHS DURING FIVE-YEAR PERIOD

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STATISTICS ARE COLD! But — they have been the measuring stick for the public health worker since the word statistics was coined. By keeping adequate records we can measure the cooperative accomplishments of the medical and allied professions in the control of human ailments.

The deaths from cancer in Indiana for the past five years are presented to give a true picture of any such accomplishments. We believe that with better public awareness and the rapid advancement of medical knowledge we can show advancement in this field.

A five-year period is short to show significant change. It is noted that deaths from cancer of the so-called accessible sites have declined during this period or at least have been contained. Advances in therapeutic and diagnostic procedures no doubt have accomplished much of this.

However, bronchogenic carcinoma does not appear in such a favorable light. There has been a gradual and steady rise in the death rate in men from cancer of the respiratory system. This represents an increase from 12.7 to 16.2 per cent of the total during this five year period. This rise can also be seen on a national scale. Though women are known to have lung cancer less frequently, they also show an increase of 3.3 to 4.3.

The challenge of researchers today is to determine the many factors of our everyday life which allow this one form of cancer to be on the increase while the others are held in at least partial control.

Following is the data for the five-year period:

\* Doctor Anderson is Director of the Division of Chronic Diseases and Gerontology of the Indiana State Board of Health.

INDIANA STATE BOARD OF HEALTH STATISTICAL SERVICE  
Cancer Deaths by Site and Sex—Indiana 1948-1952, by occurrence

	NUMBER					% OF TOTAL				
	1948	1949	1950	1951	1952	1948	1949	1950	1951	1952
MALE -----	2645	2647	2655	2787	2837	100	100	100	100	100
Digestive organs -----	1236	1166	1092	1186	1170	46.8	44.0	41.1	42.5	41.3
Male genital organs -----	375	351	386	172	380	14.2	13.3	14.5	6.2	13.4
Respiratory system -----	337	352	413	441	461	12.7	13.3	15.6	15.8	16.2
Urinary organs -----	145	153	145	376	180	5.5	5.8	5.5	13.5	6.3
Buccal cavity and pharynx -----	122	72	85	91	90	4.6	2.7	3.2	3.3	3.2
Skin -----	67	48	50	64	57	2.5	1.8	1.9	2.3	2.0
Central nervous system -----	48	62	57	58	74	1.8	2.3	2.1	2.1	2.6
Other and unspecified -----	186	206	182	157	184	7.0	7.8	6.9	5.6	6.5
Neoplasms of lymphatic and blood forming tissues -----	129	237	245	242	241	4.9	9.0	9.2	8.7	8.5
FEMALE -----	2841	2889	2875	2951	2883	100	100	100	100	100
Digestive organs -----	1080	1075	1072	1075	1056	38.0	37.2	37.3	36.4	36.5
Uterus -----	531	528	510	473	448	18.7	18.2	17.7	16.0	15.5
Breast -----	491	491	487	516	496	17.2	17.0	16.9	17.4	17.2
Other female genital organs -----	162	160	163	203	192	5.7	5.5	5.7	6.9	6.7
Urinary organs -----	87	77	96	111	91	3.1	2.7	3.3	3.8	3.2
Respiratory system -----	93	92	111	124	124	3.3	3.2	3.9	4.2	4.3
Skin -----	37	46	44	32	31	1.3	1.6	1.5	1.1	1.1
Buccal cavity and pharynx -----	27	19	23	23	26	1.0	.7	.8	.8	.9
Central nervous system -----	28	37	52	45	39	1.0	1.3	1.8	1.5	1.4
Other and unspecified -----	188	202	157	176	192	6.6	7.0	5.5	6.0	6.7
Neoplasms of lymphatic and blood forming tissues -----	117	162	160	173	188	4.1	5.6	5.6	5.9	6.5



# STATISTICAL REPORT OF THE INDIANAPOLIS GENERAL HOSPITAL CYTOLOGY LABORATORY

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**T**HE CYTOLOGY LABORATORY\* of the Indianapolis General Hospital has completed its second 12 months of operation. To demonstrate progress, the annual report for the second year will be followed by a brief summary of the first year in each division of classification. The figures quoted are numbers of cases, not individual slides examined, slides per case ranging from 1 to 30. The word "case" is used to represent all of the material sent to the laboratory at one time on any given patient and reported under one accession number. Routine screening of all women over 35 years of age has been practiced in the Gynecologic clinic; other cases are for the most part from symptomatic patients.

During the second 12 months of operation a total of 1,102 cases prepared by Papanicolaou technique were examined. This total consisted of:

Gynecological specimens -----	882
(Vaginal, endocervical and endometrial aspirations)	
Bronchial aspirations -----	50
Sputums -----	59
Pleural fluids -----	42
Ascitic fluids -----	22
Cul de sac aspirations -----	3
Gastric balloons -----	11
Urines -----	20
Bladder washing -----	1
Prostatic smears -----	2
Brain tumor fluid -----	1
Lymph node drainage -----	2
Parotid gland aspiration -----	1
Retroretinal eye aspiration -----	1
Skin abscess -----	1
Breast abscess -----	2
Abdominal solid tumor aspiration -----	1
Cyst aspiration -----	1

In comparison with the first 12 months of operation, there was a total increase of 100 cases. The number of gynecological specimens was,

however, approximately the same with the increase showing most prominently among other types, especially bronchial aspirations and pleural and ascitic fluids. The technical problems experienced the first year were greatly minimized during the second 12 months.

Cases examined were reported as Class I or II, meaning negative for cancer; Class III, suspicious; or Class IV or V, positive for cancer. During the second year a total of 86 cases were reported as Class III, suspicious. These consisted of:

Gynecological specimens -----	66
Bronchial aspirations -----	5
Sputums -----	7
Pleural fluids -----	1
Ascitic fluids -----	3
Urines -----	3
Lymph node drainage -----	1

Of the 66 gynecologic cases, 23 were later proven to be carcinoma *in situ* of the cervix. Out of all the remaining cases reported as Class III, suspicious, 14 were proven by subsequent biopsy or operation to be invasive carcinoma. The diagnosis is still unknown in 32 of these 86 cases—that is, there has not as yet been a histologic examination. The first year 54 cases were reported as Class III; 9 were later proven to be carcinoma *in situ*, 10 carcinoma, 2 sarcoma, and the diagnosis is still unknown in 15 cases.

During the second year, 55 cases were reported as positive, Class IV or V; 29 of these were gynecological specimens of which 25 have been confirmed, 3 are considered false positives, and 1 case is still unknown. Of the 25 confirmed positives 17 were shown by histologic examination to be epidermoid carcinoma, 5 adenocarcinoma, 1 undifferentiated carcinoma,

1 Ca *in situ*, and 1 cystadenocarcinoma of the ovary. Two of the three false positives were cases in which atypical endometrial cells were present in the endocervical smear. These were considered at the time to be malignant but upon histologic examination one case was reported as an endometrial hyperplasia of the glandular and stromal elements and an endometrial polyp and the other case as secretory endometrium with the cells of the lower portions of the endometrial glands showing some atypicalities. The third false positive was a case in which the curettage and conization specimen was reported by the pathologist as "blood clot and endometrium, not diagnostic" and "chronic cervicitis with Nabothian cyst formation." One piece of the cone was not received in the laboratory for examination and the patient refused further investigation. Although it is not felt that a neoplasm has definitely been ruled out in this case, it has nevertheless been counted as a false positive in this series. The one case in which the diagnosis is still unknown is a patient whom the social service department has not been able to locate for follow-up studies. In comparison, during the first year 19 gynecological specimens were reported as positive, 14 have been confirmed, 3 are considered false positives, and 2 are still unknown.

The positives in other fields during the second year were:

Bronchial aspirations .....	4
Confirmed... 4 False... 0 Unknown... 0	
Sputums .....	3
Confirmed... 1 False... 1 Unknown... 1	
Pleural fluids .....	11
Confirmed...10 False... 0 Unknown... 1	
Ascitic fluids .....	2
Confirmed... 1 False... 1 Unknown... 0	
Cul de sac aspiration .....	1
Confirmed... 1 False... 0 Unknown... 0	
Gastric balloon .....	1
Confirmed... 1 False... 0 Unknown... 0	
Urines .....	2
Confirmed... 2 False... 0 Unknown... 0	
Parotid gland aspiration .....	1
Confirmed... 1 False... 0 Unknown... 0	
Abdominal solid tumor aspiration.....	1
Confirmed... 1 False... 0 Unknown... 0	

This makes a total for the second year of 55 positives (Class IV or V). Of these 47 have been confirmed by subsequent histologic examination, 5 are considered to be false positives, and 3 are still unknown. The first year there

were 46 positives, 36 were confirmed, 4 were considered false, and the diagnosis is still unknown in 6 cases.

In summary, combining Classes III, IV, and V, of the 1,102 cases examined the second year, 61 cases of proven carcinoma plus 23 cases of proven cervical carcinoma *in situ* were reported in comparison to 48 cases of proven carcinoma and 9 cases of carcinoma *in situ* in the 1,002 cases examined the first year.

There has not been enough time lapse to make it possible to compute a percentage of accuracy because of the cases in which a diagnosis has not yet been substantiated. In estimating the accuracy of positive classification, the two years' statistics are approximately the same, averaging about 90% the second year and 89% the first year. It is always difficult, perhaps even impossible, to calculate accurately the number of false negatives unless only a controlled group is studied. However, upon checking all of the histologic diagnoses of carcinoma or carcinoma *in situ* of the uterine cervix made in Indianapolis General Hospital during the period of time covered by this report for the second year, it was found that in every case in which cytologic studies were done a suspicious or positive report was given. Malignant cells were not demonstrated in one ascitic fluid and one pulmonary specimen proven later to be cases of carcinoma. Another pulmonary case is still in question; in this instance no tissue sections have been obtained to substantiate a fairly certain clinical, malignant diagnosis. In the case of the ascitic fluid, a repeat was secured, however, because the patient generation of most of the cells present. No repeat was secured, however, because the patient was terminal. Re-examination of the slides in these cases after the diagnosis was established failed to reveal cells that could be considered malignant. The number of false negatives reported during the first year is not known.

The cases which best demonstrate the contribution of the cytology laboratory as a part of the diagnostic unit of the hospital are the proven cases of malignancy which were diagnosed initially by routine Papanicolaou smears. Following are three similar cases studied during the second year.

**Patient A** was a 64-year-old woman who was hospitalized for treatment of bronchiec-

tasis. Papanicolaou vaginal and endocervical smears were made during a routine pelvic examination and were reported as Class IV, Positive. The consultant gynecologist considered the cervix to be normal in appearance but advised a dilation and curettage and conization on the basis of the positive cytologic report. The subsequent pathologic report was epidermoid carcinoma of the cervix, insufficient for grading, with early invasion. The patient was treated with radium.

**Patient B** was a 69-year-old man who was hospitalized with a history of marked weight loss, persistent cough, and occasional hemoptysis. Tuberculosis was suspected but all cultures and smears were negative. A neoplasm was considered but bronchoscopic examination was negative and x-rays were suggestive but not conclusive. The patient's condition improved on antibiotic therapy and the diagnosis though uncertain was felt to be a chronic inflammatory condition. A cytologic study was then done on a sputum sample and malignant cells were found (Class V). Exploratory thorotomy revealed an inoperable neoplasm with pleural extension. The pathologic report was adeno-carcinoma of the lung.

**Patient C**, a 31-year-old woman, had

routine vaginal and endocervical Papanicolaou smears made in the Gynecologic Clinic. These smears were reported as Class III, Dyskaryosis. A subsequent pathologic report of a biopsy of the cervix was carcinoma *in situ*. The patient was hospitalized and a conization was done but no lesion was found in the tissue obtained. Her Papanicolaou smears, however, continued to contain positive cells. When a total hysterectomy was performed, extensive carcinoma *in situ* was found high in the endocervix but no invasion was seen at any point.

## SUMMARY

The cytology laboratory examined a total of 1,102 cases during the second year representing an increase of 100 cases over the previous year. When the suspicious and positive reports are combined, 61 cases proven to be carcinoma plus 23 cases proven to be carcinoma *in situ* were reported the second year in comparison to 48 cases of carcinoma and 9 cases of carcinoma *in situ* reported the first year. The cytologic method has demonstrated its value in cases where it has been the initial diagnostic test.

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\* This laboratory is indebted to the Marion County Cancer Society for financial support.

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## AMA EXHIBIT DISPLAYED AT SMITHSONIAN INSTITUTE

By special invitation of the museum, the American Medical Association will display its exhibit, "The Organs of the Human Body," at the Smithsonian Institution in Washington, D. C., during 1954. After this year, this exhibit will be available for showings in other museums throughout the country.

A new exhibit—"The Physician's Responsibility in Highway Accidents"—calls the doctor's attention to the fact that he should warn patients about the dangers of driving while under the influence of sedatives, antihistamines or anticonvulsive drugs. For professional showings only, this exhibit may be booked through the AMA's Bureau of Exhibits.



# The *Journal*

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*Devoted to the interests of the medical profession of Indiana*

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## CANCER OF THE BREAST AND PREGNANCY

THE COEXISTENCE of carcinoma of the breast and pregnancy or lactation comprises less than 3 percent of all cases of breast cancer. Until recently, the coincidental occurrence of the two conditions was looked upon with extreme pessimism. There are several reasons for the general pessimistic attitude regarding this serious combination of conditions; most of the cases occur in women in the age group under 40 where the prognosis of cancer is generally considered less favorable; the physiological enlargement of the breast associated with pregnancy and lactation interferes with the detection of small lesions; many carcinomas occurring at this time may be confused with inflammatory lesions; and also many reports, especially those of Geschickter<sup>1</sup>, Haagensen and Stout<sup>2</sup> stress the futility of curative treatment of breast cancer associated with pregnancy.

Prior to 1948, Haagensen considered pregnancy as one of the conditions which by itself

placed a carcinoma of the breast in the class designated by him as categorically inoperable.

In 1948, Haagensen in a discussion of carcinoma of the breast showed a willingness to modify his earlier position with regard to the treatment of carcinoma of the breast occurring in pregnancy and lactation. He stated, "In view of Harrington's experience, it may be that our group of cases was a particularly unfortunate one and that radical mastectomy is justified in these patients, provided, of course, that the disease is locally operable"<sup>3</sup>.

In 1940, Harrington reported 99 cases of breast carcinoma associated with pregnancy or lactation in a series of 5,026 cases. In the cases without axillary metastases, there was a 15 year survival of 22.2 percent as compared to a 15 year survival of 41.9 percent in the nonpregnant group<sup>4</sup>. In smaller series of cases, White<sup>5</sup>, and also Hochman and Schreiber<sup>6</sup> have reported favorably upon the treatment by radical surgery

of carcinoma of the breast occurring in pregnancy. The review of the literature of this subject in the report by White is particularly encouraging. In this review, he found survival of 22.4 percent of patients, reported in the decade 1941-1950. Tomlinson and Eckert<sup>6</sup> treated 100 cases of breast carcinoma which, according to the classification of Haagensen and Stout, were categorically inoperable. The only two patients in this group who survived for over five years were pregnant at the time of the operation.

There have been many experimental studies which support the belief that the increased production of hormones during pregnancy does accelerate the development and growth of breast carcinoma. Also, in cancer-susceptible strains of mice, mammary cancer has been produced by the administration of estrogenic substance. But such conclusions from animal experimentation are not always transferable to human subjects. An interesting observation is that unmarried and infertile women show a higher incidence of breast cancer than married and multiparous women. Although pregnancy in humans may have no accelerating effect on a hormonal basis, the physiological vascular changes in the breast probably accelerate the growth of the neoplasm and its spread by rapid invasion of the lymphatics and the blood stream.

The findings of existing studies indicate that management of breast cancer complicated by pregnancy should be identical to the management

of the disease in nonpregnant women, and that the prognosis depends more upon the stage of the disease and the adequacy of the treatment—radical mastectomy and irradiation—than on its association with pregnancy.

From the foregoing observations, it is obvious that frequent and careful breast examinations should be a routine part of the prenatal care of all women. The discovery of any tumor of the breast during pregnancy or lactation should demand the same investigation as though the patient were not pregnant. No case of breast cancer should be denied the opportunity for cure solely on a coexistence with pregnancy or lactation.

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#### MEDICAL FORUMS

THE GENERAL PUBLIC'S INTEREST in medical and health information far exceeds the facilities for obtaining it.

At least, the facilities for communicating reliable and dependable health information were somewhat deficient prior to the advent of medical forums.

Medical forums were first conducted for large general audiences by the Pinellas County Medical Society in St. Petersburg, Florida. In Indiana the Vanderburgh County

Medical Society, in conjunction with the Evansville Press, has conducted several highly successful forums.

Recently the story of the forums and the details of how they were arranged and conducted were reported to the I.S.M.A. Council. Printed reports were sent to all the component societies of the Association.

Advantages of the medical forum plan are many, and the disadvantages are practically non-existent. In the communities where for-

ums have been held, the public, the medical societies and the cooperating newspapers have all been enthusiastic and highly gratified by the programs.

This type of public meeting is adaptable to any size community, or to neighborhoods of larger cities. It furnishes authentic and reliable teaching on the medical subjects in which the public is most interested. It is a

public spirited enterprise to which the newspapers are eager to contribute.

Like so many community projects it is an undertaking to which many people give to help others, and then find that they themselves are profiting tremendously. The good will which has accrued to the individual physicians of the localities where forums have been held is a significant by-product.

## CANCER AND THE PRESS

**I**N RECENT YEARS, information about cancer directed towards the lay public has been characterized by a hopeful tone. This change from earlier techniques which were calculated to frighten people into action by emphasizing the horror of terminal cancer has been generally applauded by the profession, many physicians having been concerned with the increasing incidence of cancerphobia. To what degree the hopes being held out by current educational literature are justified remains highly controversial and is not appropriate to this discussion. What is pertinent is the fact that no good purpose is served by certain articles in recent magazines which tend to undermine the patient's confidence in his physician's integrity and professional capability. Such an article dealing specifically with cancer diagnosis and treatment appeared in the January, 1954 issue of the *Woman's Home Companion*, entitled "How You Can Double Your Chances Against Cancer." The author, Alfred Q. Maisel, citing a number of cases and quoting both from the medical literature and from several eminent physicians is able to slant information in such a manner that only the better informed would fail to lose confidence in their physician's ability to deal with cancer. Moreover, Mr. Maisel sets up four conditions which an institution must meet before he considers it a fit place for the diagnosis and treatment of cancer. A list of approximately 150 thus-qualified institutions is presented, and the impression is promulgated that by availing oneself of the services of one of these centers, one's chances against cancer are doubled. It is interesting that in Indiana only the Indianapolis City Hospital and the Indiana University Medical Center make the elite group; it is equally inter-

esting that in Minnesota, only the University of Minnesota Hospital at Minneapolis is listed; a nearby institution of some renown failed to make the list.

Although an impression of tacit approval of the article by the American College of Surgeons and the American Cancer Society is implied by Mr. Maisel, these organizations gave quick and loud statements of nonresponsibility. Dr. Paul R. Hawley, writing in the *Bulletin of the American College of Surgeons* under the caption "Not On Our Doorstep," clearly outlines the steps taken by the College to prevent the publication of the article, but his advice fell on deaf ears.

Cancer is being discovered and treated today in many communities in Indiana and other states as skillfully and effectively as in those institutions listed by Mr. Maisel. Even if this were not true, it is obvious that all persons in Indiana wanting examination and treatment for cancer could not possibly be handled by the two institutions listed. Such an article serves only to berate confidence in local facilities specifically and to dispel hope of chances against cancer generally.

Medicine today seems to make red-hot journalistic copy. Because the subject is complex and not well understood by most readers, it is not difficult to slant facts towards the sensational—a technique designed to increase circulation and newsstand sales.

That editors may at times be misguided by the enthusiasm of free-lance writers is easily appreciated. A deeper sense of public responsibility, however, in matters so fundamental as the giving of medical advice to their readers should lead editors to seek and heed the counsel of those qualified to give such counsel. C.S.C.



## IS CANCER QUACKERY DECLINING?

The following guest editorial was written by Rollis S. Weesner, Executive Director of the American Cancer Society, Indiana Division, for this annual Cancer issue of THE JOURNAL.

**F**ROM MANY INDICATIONS quackery in the treatment of cancer is declining. It still remains, however, as a major problem that may never be completely stamped out.

This decline is not coming about because of orthodox, ethical advancement in handling of the disease, but rather from public information and education provided by organized medicine and especially leaders in the field of scientific research and surgical advancement. No longer do we read the once frequent newspaper headline, "New Cancer Cure Found"—"New Cancer Cure Claimed." When "Cancer Cure" is headlined now, the story usually describes some medically recognized advancement in surgery or radiation.

This fortunate situation is resulting from the fact that science-minded writers are more and more being employed by newspapers, and doctors and scientists are willing to discuss freely with them the experiments and results they either achieve or hope to achieve. No longer does the writer for a thirsty public need to acquire information from the charlatan and advertiser to gain his blacktype headline.

There are, of course, other deterrents to quackery that are adding their toll such as the literature and growing number of volunteer educators of the American Cancer Society; the fine policing of the State Medical Registration Board; and the enforcement of the U. S. Public Food and Drug Act.

### Why People Turn to Quackery

A sick person develops many complexes, fears, dreads, peevs, notions and suspicions. This is particularly true if the illness is of long duration and it is usually even more accentuated if the patient has cancer.

Many cancers are of long duration and the

patient has constant need of a great deal of psychotherapy. If he does not get it from his family and his physician, he will seek it elsewhere. The quack is usually a pretty good psychologist and his promises of cure or relief are presented in a manner that are difficult to resist. Who hasn't wasted his money at some time or another on a "hotter spark plug inducer" or a "gasoline saver"? And are not most food fads plain quackery? Intelligent people in the best of health fall for these things by the millions. So, why wouldn't the man who is waiting to die be attracted to anything that merely promises in some way to help him?

We know that the cancer patient is wasting his money and too often wasting the precious time that is his greatest hope. We know that his family and friends become impatient and often contribute to his turning to the nostrums of the quack. The doctor, of course, does not contribute directly to this situation, but he should always be cognizant of the terrific psychologic conflict that exists and should counter with a better brand of his own psychology along with his treatment.

### People Becoming More Patient

The public is coming to realize that cancer is probably civilization's greatest challenge to the mind of man. More and more the fact is understood and appreciated that "overnight" or accidental discovery of a cure for cancer is improbable. They appreciate the magnitude of the problem and follow with great interest even the smallest advancement. They do not expect miracles from their doctors but they do expect sympathetic understanding and genuine interest when illness strikes, especially cancer. They want him to know, or direct them to someone who does know, the best treatment for their disease. They want and need that feeling of interest and guidance that reduces the natural psychological trauma they are entering upon. A sure way to increase the trend back toward quackery is to label them hypochondriacs or persons who are going to die anyway and why bother.

Yes, the literal disappearance of "Cancer

Cure" headlines and the decline in cancer quackery is encouraging. The heart-rending letters and telephone calls that used to follow "Cancer Cure" stories have subsided. The requests for information on questionable "Cancer Hospitals"

and "Treatments" are only about one to ten of a few years ago.

The "Cancer Cure" headline may rise again someday. But when it does, we hope it will really warrant praise and jubilation.

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Despite the myths about the blessings of retirement, no satisfactory substitute for self-support through work has been found for the person who wants to maintain his customary standard of living, to be useful, to have a feeling of achievement, and to contribute something to society as long as he is able.

—*The Mississippi Doctor*

#### PROFESSIONAL FILMS ON CANCER AVAILABLE

The Indiana Division of the American Cancer Society has the following scientific films for loan to any professional group in the state. They are in sound and color and highly authentic. Running time approximates 30 minutes for each. Make requests to American Cancer Society, Indiana Division, 325 Board of Trade Building, Indianapolis 4, Indiana.

1. Cancer: The Problem of Early Diagnosis
2. Breast Cancer: The Problem of Early Diagnosis
3. Gastro-Intestinal Cancer: The Problem of Early Diagnosis
4. Uterine Cancer: The Problem of Early Diagnosis
5. Oral Cancer: The Problem of Early Diagnosis
6. The Exfoliative Cytologic Method in the Diagnosis of Gastric Cancer
7. What is Cancer? (Nurses)

*Recommended for Lay Groups (running time approximately eighteen minutes):*

8. Breast Self-Examination (Lay education)
9. The Warning Shadow (Lay education—lung)

# The President's Page

FELLOW MEMBERS OF I.S.M.A.:

SOMEONE always asks, What is the State association doing? They must be doing something, as there is a meeting at Indianapolis every Sunday and part of the time during the week. These men go to Indianapolis and spend nearly the whole day at these meetings. There are around 275 physicians on state committees and in official positions. These are hard-working committees and are trying their best to solve some of our problems. Following are a few of the recent happenings:

The Grievance Committee, which meets once a month, has asked to have a psychiatrist added to their group to evaluate some of their problems. The Council raised some of our Executive staff salaries to bring them more nearly in line with the surrounding states. They gave the Publicity Committee some right money to tell the story of Indiana Medicine and what is being done in our state. This will probably be accomplished via radio and television.

The 29th Annual Conference of County Medical Society Officers was held on March 7 with around 125 physicians present. You would have been interested to hear the panel discussion and also Dr. Wilson, from the Washington office of the A.M.A., discuss what had been done by this Congress; how well the medical forums have been worked out (your own Society can well take a look at the Evansville plan); how legislation for 1955 is shaping up. You had better decide how your Society will vote on free choice of physician for industrial cases.

The Polio Foundation came into Indiana to inoculate the second-grade children in eight of our counties, which have had the most polio, with the new Salk vaccine; the first and third grades to be used as controls.

The Indiana Blue Shield is working on a new contract that will have fees that more nearly approximate our present fee schedule.

The Medical Education and Hospitals Committee has a large number of excellent recordings on medical subjects on tape and wire for use free by either societies or individuals. Several of our doctors who have been confined to bed have taken a post-graduate course via the tape recorder while getting well.

You can expect to see your picture in THE JOURNAL, as the field representatives have cameras and are taking interesting shots at the various meetings.

The meeting of all the Blue Shield Plans in Chicago on February 6, 1954, took the stand that anesthetic, x-ray and pathology were medical practices and should be included in the Blue Shield policy rather than in the Hospital contract.

The A.M.A. Regional Conference on Veterans' Care will meet in Indianapolis on March 21, 1954. We have invited the Presidents and Secretaries of the five surrounding states to come a day earlier and go over the problems affecting our six states. We felt that if the group could get together on our mutual problems it would give us a stronger position on the A.M.A. level.

*Wm Harry Howard M.D.*



## INDIANA UNIVERSITY SCHOOL OF MEDICINE DEAN TO DIRECT STATE CANCER FUND DRIVE

**D**R. JOHN D. VAN NUYS, dean of the Indiana University School of Medicine, will direct the \$500,000 annual fund-raising drive for the Indiana Division of the American Cancer Society in April.

Acceptance of the responsibility by Dr. Van Nuys was announced by John Biel, Terre Haute, president of the State Society, with the comment "this is one of the highest tributes that could be paid Hoosier laymen who have been working to conquer cancer. His willingness to assume this task on top of his many other responsibilities will be an inspiration to the thousands of volunteers working for cancer control throughout the state."

Dr. Van Nuys said he accepted the post with "a deep sense of appreciation" for the assistance given the Medical Center by the cancer society in its efforts to contribute to the conquest of the disease.

"The research program of the Indiana University School of Medicine has been expanded and supported materially through the efforts of the Society during the past several years," he said. "In addition to the direct grants which the school has received from the Indiana group for studies of this malignancy, the organization has been responsible for enlisting the active financial support of cancer research from other groups."

The campaign chairman has been dean of the medical school since 1947 and has been associated with the medical center since he was grad-



**Dr. John D. VanNuys**

uated from the school of medicine there in 1936. He is the son of Dr and Mrs. W. C. Van Nuys. His father was superintendent of the Indiana Epileptic Village in Newcastle for many years. Dr. John Van Nuys was medical director of all university hospitals from 1942 to 1947.

In addition to extensive physical expansion of the medical center during his six-year service as dean, research activities have increased as reflected by the fact that funds for such work have increased 600 per cent. The increase in research has been principally in cancer and children's diseases. Support has come from national as well as state sources.

## INDUSTRIAL HEALTH CONGRESS THROWS NEW LIGHT ON WORKERS' HEALTH

**T**HE 14th annual Congress on Industrial Health, held at the Brown Hotel, Louisville, February 24-25, threw new light on the problems encountered in the maintenance of the health of factory and white-collar workers. The meeting was held under the sponsorship of the American Medical Association's Council on Industrial Health.

Physicians, management representatives, and labor leaders who attended the congress went home with a better understanding of the situation, particularly as it exists in small plants. The meeting presented examples of successful projects, both large and small.

A considerable portion of the program was devoted to panel discussions. The participants in these were outstanding figures in the respective fields covered.

One panel considered the stress effects on workers in industry. It was brought out that stress disorders, such as neuroses, heart conditions, and ulcers, are increasing. The victims are principally men, although women are not immune. It was the consensus that more consideration should be given by industry to this problem.

Another group discussed the effect of prolonged illness. It was concluded that this problem represents a challenge to industrial medicine and management.

### Discuss Preventive Medicine

Three members of the medical department of E. I. du Pont de Nemours & Co., Wilmington, Del., related the preventive medicine program which is being carried out in some of the company's 100-odd plants and laboratories. This presentation included methods of handling mental and alcoholic problems. In the latter instance, a program has been worked out in cooperation with members of Alcoholics Anonymous which has been signally successful, resulting in the rehabilitation of two out of every three excessive drinkers.

Another group discussed the industrial implications of emphysema, including the clinical as-

pects, pathologic physiology, histopathology, radiography and therapy.

Difficulties faced by small plant operators in providing medical care for small groups of workers were presented at another session. It was brought out that the problems can be and are gradually being solved. How plant emergency services may be established and maintained was explained.

Frank G. Dickinson, Ph.D., Chicago, director of the A.M.A.'s Bureau of Medical Economic Research, reported that improvements in medical service have greatly increased the economic value of industrial workers.

"In 1900, perhaps one-half of the industrial workers 20 years of age could expect to live to the age of 65," Dr. Dickinson said. "Now, more than four-fifths of them are destined to reach that retirement period."

"The decline in mortality during the working years of life has contributed greatly to economic progress. It has contributed to the solution of some social problems—the probability of becoming an orphan, for instance, has been cut in half."

An afternoon was devoted to the problem of how disasters—both those caused by military action and those resulting from natural causes—may be met. That portion of the program was under the joint sponsorship of the Council on Industrial Health and the Council on National Emergency Medical Service of the A.M.A.

### C. D. Safeguards Outlined

One phase of this was covered from the standpoint of civil defense. The role of the Federal Civil Defense Administration in this program was presented by Mrs. Katherine G. Howard, Washington, deputy administrator of the F.C.D.A. Mrs. Howard pointed out that manufacturing communities would be high on enemy target lists.

"American industrial might has been a major factor in winning two consecutive World Wars," she said. "No potential aggressor could contem-

plate a third global conflict without first planning to eliminate the sources of our productive power beforehand."

It is up to the F.C.D.A. to develop, in collaboration with other public, semi-public and private agencies, the safeguards against possible attack, she added.

Dr. Charles L. Dunham, Washington, chief of the medical branch, division of biology and medicine, U.S. Atomic Energy Commission, said that while the situation created by an atomic attack would be terrific, the individual problems and requirements would be familiar ones.

Defense against biological warfare centers upon rapid recognition, reporting and treatment of cases, in the opinion of Dr. John J. Phair, Cincinnati, professor of preventive medicine in the University of Cincinnati College of Medicine. Dr. Phair, a consultant to the F.C.D.A., said that in biological warfare, man would be the target. This would be accomplished directly through causing sickness or death, or indirectly through limitation of food crops by creating additional disease hazards.

### Leadership Needed

Col. James H. Defandorf, Washington, specialist in chemical and biological warfare, F.C.D.A., said new and highly toxic chemical warfare agents, such as the nerve gases, and the greatly increased speed, capacity and range of military aircraft, make chemical attacks a serious hazard in critical target areas.

"Relatively few bombers would be required to saturate a large area with casualty-producing or lethal concentrations of nerve gas," Col. Defandorf reported.

The public needs to be prepared for psychological warfare, in the opinion of Dr. Ozro T. Woods, Dallas, mental health consultant to the F.C.D.A., who stated:

"Our people are critically in need of leadership in our defense program. They are confused about our efforts because they have had no clear, complete official statement about all the attacks being made on us. We need to be told about our strength in the presence of danger and how we can make ourselves stronger."

How Vicksburg, Mississippi, met a disaster by putting into effect a previously organized program was related by two speakers. Vicksburg,

on December 5, 1953, was hit by a tornado which killed 38 people, injured 385, and caused a property damage of more than \$25,000,000.

Within one hour after the tornado struck, disaster units were in full swing, it was reported by Dr. George H. Martin, Vicksburg, chairman of the Mississippi State Medical Association's committee on industrial health.

"Three days after the tornado, rehabilitation was well under way and further demolition and repair turned over to private contractors," Dr. Martin said.

Dr. Lawrence W. Long, Jackson, Miss., chairman of the Mississippi State Medical Association's committee on emergency medical service, explained how this disaster program had been established. Dr. Long attributed the success of the preparatory work to the fact that the program was aimed at community and state peacetime problems rather than to the possible effects of atomic or other warfare.

"We did not meet with much response until we moved away from the atomic bomb and war field into the disaster field of our state and communities, such as tidal waves, cyclones or tornadoes, and boat, air or rail disasters," he said. "We began to see enlightenment in the faces of our people with this plan."

### Mayo Doctor Honored

The annual dinner, given in cooperation with the Jefferson County Medical Society, was featured by the presentation of the Presidential Award of 1953 to Dr. Frank H. Krusen, Rochester, Minn., for his contributions to the employment welfare of the handicapped. The citation was presented to Dr. Krusen, who is head of the section on physical medicine at the Mayo Clinic, by Dr. Ross T. McIntyre, Washington, president of the President's Committee on Employment of the Physically Handicapped.

Dr. Krusen, in response, said that "proper restoration of handicapped persons depends on three things: (1) appropriate, definitive treatment and physical rehabilitation of the handicapped person in the hospital; (2) proper vocational rehabilitation, and (3) well-established programs for employment of the handicapped."

Dr. Donald A. Covalt, New York, clinical director of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, gave a dramatic demonstration



of results of the institute's program. Five patients—four with serious paralysis as the result of accidents—were presented as examples of persons who had been made self-sufficient after having been helpless for long periods of time.

Dr. Robert A. Kehoe, Cincinnati, director of the department of preventive medicine and industrial health at the University of Cincinnati College of Medicine, stressed that industry and medicine were partners in the maintenance of the health of workers.

Rehabilitation work in Louisville was described by Dr. J. Murray Kinsman, Louisville, dean of the University of Louisville School of Medicine. Dr. McIntire reported on the blood program in industry and told of the need of that project.

### New Officers Named

Several announcements of importance were made during the congress. The Council on Industrial Health made it known that Dr. William P. Shepard, New York, second vice-president, health and welfare division, Metropolitan Life Insurance Company, had been elected chairman of the council. Dr. Shepard succeeds Dr. Anthony J. Lanza, New York, director of the Institute of Industrial Medicine, New York University-Bellevue Medical Center.

Two new members of the council also were elected. They are Dr. Lemuel C. McGee, Wilmington, Del., medical director of the Hercules Powder Company, and Dr. Charles F. Shook, Toledo, medical director of the Owens-Illinois Glass Company. They succeed Dr. Lanza and

Dr. Charles D. Selby, Port Huron, Mich., whose terms expired.

Dr. George F. Lull, Chicago, secretary-general manager of the A.M.A., announced that the association had presented citations to Drs. Lanza and Selby for their distinguished service in the field of industrial health. These were the first industrial health citations awarded by the A.M.A. Both physicians have been leaders in the movement for better health conditions among workers and were potent forces on the Council on Industrial Health over a long period of years.

Seven physicians—six American and one Canadian—were nominated by the council for appointment to an American-Canadian advisory committee on industrial health to the World Medical Association. The W.M.A., representing 700,000 physicians of 46 national medical societies, is planning the establishment of an International Committee on Industrial Health for the benefit of industrial workers everywhere.

Announcement of the nominations, subject to confirmation by Dr. Louis H. Bauer, New York, secretary-general of the World Medical Association, was made by Dr. Carl M. Peterson, Chicago, secretary of the council. Those proposed for the advisory committee are: Drs. Henry H. Kessler, Newark; George Saunders, New York; Max R. Burnell, Detroit; Grant Cunningham, Toronto; Carey P. McCord, Ann Arbor, Mich.; John Poutas, Cambridge, Mass., and Robert A. Kehoe, Cincinnati.

A joint conference of the Council on Industrial Health and chairmen of state medical society committees on industrial health was held on the day before the opening of the congress.

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### WE NEED COPIES OF FEBRUARY, 1954 JOURNAL

The entire extra supply of February, 1954 copies of *THE JOURNAL* has been exhausted. We are still receiving calls for this issue. If you do not keep a file of *THE JOURNAL* and have finished reading your copy, the staff of *THE JOURNAL* office will be grateful if you will return your copy to 1017 Hume Mansur Building, Indianapolis 4, Indiana. In this way we can fill the orders we are now holding for single copies of that issue.

If you keep your copies of *THE JOURNAL* for later reading or for reference this appeal is not directed to you. Some specialists not finding an article in their field, do not keep their *JOURNALS*. We would like to have these.

## 3,000 PHYSICIANS INVITED TO RETURN FOR I.U. SCHOOL OF MEDICINE ALUMNI DAY

Limited attendance clinics, a discussion of medical economics and the traditional fried chicken-strawberry shortcake picnic, are on the program for the seventh annual Alumni Day being held May 12 by the graduates of the Indiana University School of Medicine.

The day's activities, including events of special interest for both physicians and their wives, are expected to result in a record attendance with many alumni returning from all parts of the country. Announcement of the program has gone to the more than 3,000 physicians granted M.D. degrees by Indiana University. Special invitations have gone to all physicians whose classes were graduated in years ending in '4' and '9' urging their attendance at class reunions.

A new feature of this year's program is the scheduling of four morning clinics—medicine, surgery, obstetrics and gynecology, and pediatrics—which may be attended by the alumni. Also on the morning program will be informal reunions, guided tours of the Medical Center, and an open house at the Student Union building and swimming pool.

At noon the alumni move to the picnic luncheon, held under a huge tent, where the menu starts with heaping platters of fried chicken and ends with big servings of fresh strawberry shortcake. Members of the reunion classes will eat together and pose for the class pictures afterwards.

The afternoon session for alumni will be held in the auditorium of the School of Medicine where many of the group attended lectures and seminars during their student days. At 2 o'clock Dr. James O. Ritchey, president of the alumni association, will open the business session at which reports of the officers and committees will be given. Installation of officers for the 1954-55 year will take place and nominations will be received for association officers to serve in 1955-56.

Frank G. Dickinson, Ph.D., known to most physicians as the director of the A.M.A. Bureau of Medical Economic Research, will speak at the afternoon session. His subject, 'Some Current Problems in Medical Economics' is one in which every physician is interested. Dr. Dickinson has long been regarded as a leading authority on medical economics and his reports on this subject are widely quoted.

Also on the afternoon program will be Dr. John D. VanNuys, dean of the School of Medicine, who will present his annual 'State of the Medical School' report. His remarks will be of particular interest to the alumni since a part of the report will deal with progress toward construction of the long-sought Medical Science building and other developments on the campus.

Plans are also under way to have a third speaker on the afternoon program.

A special committee, headed by Mrs. J. Neill Garber, is planning a series of events during the day for the wives of physicians. This program will include participation in the noon luncheon and other activities designed especially for the ladies.

Since Alumni Day was inaugurated in 1948 the annual meetings have brought hundreds of physicians back to the campus where they have observed with enthusiasm the continuing development of the Medical School and other facilities on the campus. Last year the program was postponed from the traditional May 12 date until late September when Alumni Day was held in connection with the 50th anniversary of the School of Medicine and the dedication of the new Student Union building.

## INDIANAPOLIS MEDICAL AUXILIARY GOES INTO ACTION FOR A.M.E.F.

MRS. FRANK M. GASTINEAU\*

*Indianapolis*

**T**HE WOMAN'S AUXILIARY to the Indianapolis Medical Society began twelve weeks of activity, on February 22, for the benefit of the American Medical Education Foundation. A series of 14 informal parties has been planned. The object is for our 400 auxiliary members to get better acquainted with the hope that the ultimate result will be an outstanding contribution for the medical education fund for our Indianapolis doctors' wives.

The original idea for these parties was started last November, when Mrs. Roy V. Myers entertained the A.M.E.F. committee and their husbands with a benefit chili supper at her home.

Dr. James Denny, chairman of the American Medical Education Foundation committee for Indiana, came to the first party to explain the foundation to the members and to ask for their support. He explained that the nation's 79 medical schools are in need of funds to carry on their high standards of medical education. Last year the doctors contributed over a million dollars so that medical schools need not lower the quality of medical education nor ask for federal aid. Hoosiers are noted throughout the country for their stand against federal aid to education, so it was no surprise that for two years Indiana doctors headed the list of voluntary contributors. Doctor Denny's talk gave added inspiration to the members to support this project and they resolved to put forth special effort to cooperate with their husbands to increase this fund.

Mrs. W. Burleigh Matthew and Mrs. Roy V. Myers assisted Mrs. Frank Gastineau and turned her home into Ethel's Cafeteria for the first of the series of A.M.E.F. parties. They

wore waitress' uniforms for the opening but gave very little service, for the members had to go to the kitchen to get their bean soup and to make their own sandwiches.

Forty-five auxiliary members attended. Everyone was given a crochet hook and a ball of cotton yarn and told to produce a dish cloth. Mrs. Arthur Jay, who holds the distinction of crocheting more dish rags than any other doctor's wife, gave instructions. Hilda has made and sold over 600 dish cloths for benefits in the last few years. Mrs. J. Thayer Waldo produced the first perfect cloth but some other results were hilarious and not so fortunate.

Two distinguished guests, officers of the State Auxiliary, attended the party. Mrs. Harry Harvey, president-elect from Fort Wayne, and Mrs. W. R. Tindall, first vice-president, of Shelbyville.

Mrs. W. Burleigh Matthew entertained with a "come as you are" breakfast on March 10. Approximately 20 new recruits joined a dozen members from the original party and were initiated into crocheting dish cloths for A.M.E.F. Mrs. Charles Knowles attended the coffee bringing a record breaking number of cloths. She had made 35 in two weeks. It seems that production is now at a new high. Does anyone need a dish cloth?

"Bring your old bonnet with the dingy ribbon on it" was the theme for Mrs. Harry Pandolfo's and Mrs. Palmer Eicher's benefit given March 18. Mrs. Pandolfo turned her home into a millinery shop and every one was taught to steam, sew and press all of those last year's hats, which were turned into exclusive creations. Contributions for lessons were donated to A.M.E.F. and everyone attending benefited as well as the fund.

Mrs. Morris B. Paynter, Indianapolis Auxiliary president, assisted by Mrs. Rex M. Joseph,

\* Mrs. Gastineau is national chairman of the American Medical Education Foundation for the Woman's Auxiliary to the American Medical Association.



## A. M. E. F. BENEFIT



To inaugurate a series of 14 parties to raise money for the American Medical Education Foundation, members of the Indianapolis Auxiliary met in Mrs. Gastineau's home. Dr. James Denny, above, chairman of A.M.E.F. activities in Indiana, is enjoying his role as the only male guest. He explained aims of the A.M.E.F. campaign.

Auxiliary members made dish cloths which will be sold as part of their fund-raising drive.

gave an afternoon hobby party at her home on March 25. Guests followed their own impulses, hobbywise, from making dish cloths, sock darning and cards to piano playing. Mabs introduced her new hobby, making hand cream from an old family recipe. Jars of it were given to enthusiastic guests in return for donations to A.M.E.F. A high-calory dessert and prizes were added attractions.

Future parties planned with a definite date set are as follows:

A card party and luncheon to be given by Mrs. Charles Knowles and Mrs. Dwight Schuster. We can't omit a party for our members enjoying a game of cards.

A spaghetti luncheon "cooked up" by Mrs.

Thomas Cortese and Mrs. Albert M. Donato as only they know how.

A square dance to be given by Mrs. J. L. Arbogast, Mrs. Glenn Conway and Mrs. David Gastineau. Dr. Conway has a collection of over 350 records for square dancing and he and Mrs. Conway attend square dances in other states when on vacation. Dr. Conway will bring his records and do the calling.

Mrs. Dan E. Talbott is at present looking for 15 doctors' wives who are expert seamstresses to help make the prizes for the annual spring card party. This should be a busy group.

Mrs. James Denny is including the husbands in a benefit dinner party that she is having in her home in May.

Mrs. Frank Hall is planning a cafeteria party

at her home with the help of the waitresses from our first party.

Mrs. Clifford H. Jinks, with Mrs. James S. McBride as co-chairman, will have a book review and tea at her home.

Mrs. Charles F. Voyles, the first president of our auxiliary, plans to entertain all former presidents of the auxiliary with a luncheon. This is the first time this group has been called together

for a party. Mrs. Bert Ellis plans a picnic at her country home. This will be a large, hilarious affair as husbands will be invited. Mrs. Lester Bibler, Mrs. Harry Kerr and Mrs. J. Thayer Waldo are helping to plan this affair.

You can guess what will happen at the party to be given by Mrs. Herbert L. Egbert and Mrs. C. Basil Fausset. The party is to be held April first. They're not telling!

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## FCC Issues Public Notice Ordering Compliance With Diathermy Equipment Ruling\*

On June 30, 1953, Part 18 of the Federal Communications Commission's Rules and Regulations became applicable to the operation of all short-wave medical diathermy equipment. Since that date the operation of medical diathermy equipment which is not type approved, certified or licensed in accordance with the provisions of the Commission's Rules has been illegal, and operators of such illegal equipment are subject to the penalties prescribed by the Communications Act of 1934, as amended.

The Commission is aware that a considerable number of medical diathermy machines

which do not comply with its rules are still being used. Most of them are operated by doctors, or other persons, who either are not aware that they are violating the law or do not appreciate the compelling reasons which forced the Commission to adopt its rules governing the use of medical diathermy and other types of industrial, scientific and medical equipment.

Consequently, the Commission is using this public notice to explain the necessity for strict compliance with these rules.

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\* FCC 54-230-1872, February 19, 1954.

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## GALLUP POLL ON NURSING

A recent nationwide survey of opinion conducted by George Gallup gave an extraordinarily high rating to the nursing profession. Out of 14 professions which were rated by the interviewees, nursing and teaching received the largest number of votes. Nursing was the profession recommended by 33 percent of the voters, a figure well above that given any of the others.





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dependable control of vertigo and nausea has made  
Dramamine the most widely-prescribed product in its field.*

## Vertigo: The Labyrinthine Structure and Dramamine<sup>®</sup>

Dramamine's remarkable therapeutic efficiency is believed to be the result of suppression of the over-stimulated labyrinth. Thus it prevents the resulting symptom complex of vertigo, nausea and, finally, vomiting.

First known for its value in motion sickness, Dramamine is widely prescribed for nausea and vomiting of pregnancy, electroshock therapy, certain drugs and narcotization. It relieves vertigo of Ménière's syndrome, fenestration procedures, labyrinthitis, hypertensive disease and that accompanying radiation and antibiotic therapy.

A most impressive number of clinical studies shows that Dramamine has a high therapeutic index and minimal side actions. Drowsiness is possible in some patients but in many instances this side action is not undesirable.

Dramamine (brand of dimenhydrinate) is available in tablets of 50 mg. each; liquid containing 12.5 mg. per 4 cc. Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



## COUNTY SOCIETY OFFICERS HOLD CONSTRUCTIVE ONE-DAY CONFERENCE

A COMPOSITE PICTURE of the Washington legislative scene as it affects the medical profession was presented to county presidents and secretaries and other physicians of the Indiana State Medical Association at the 29th Annual Conference of County Medical Society Officers Sunday, March 7, in the Student Union Building at Indiana University Medical Center, Indianapolis.

"What's Going On in Congress" was the topic of the luncheon address of Frank E. Wilson, M.D., director of the A.M.A. office in Washington, D. C. He stressed the importance of "being citizens first, physicians second" in reaching conclusions concerning crucial legislation; he emphasized the need for every doctor to be well informed on pending bills, to look beyond the confines of any one profession for possible application of new laws or treaties. Doctor Wilson spoke at length on the present status of the Bricker Amendment and urged those present to repeat his message to their county societies.

Don C. Hawkins, representative of St. Paul Mercury Indemnity Company of St. Paul, Minnesota, was the second out-of-state speaker. The full text of his address is published in this issue of THE JOURNAL.

The entire morning session was used for presentation of a panel discussion, "Facing Our Problems," which was moderated by Dr. J. William Wright, Indianapolis.

Comprehensive reports were given by Dr. James M. Leffel, Indianapolis, on "The Physician and the Grievance Committee"; Dr. Wm. Harry Howard, Hammond, president of

I.S.M.A., on "Do Your Fees Make Friends or Enemies?"; Dr. D. L. Adler, Columbus, and Dr. Lester D. Bibler, Indianapolis, on "Service for the People—Emergency Call Plans" from the non-metropolitan and the metropolitan viewpoints; Dr. E. H. Clauser, Muncie, who read a paper prepared by Dr. W. L. Portteus, Franklin, on "Where Are We Going with the Voluntary Plans?" (this paper is also published in this issue of THE JOURNAL); and Dr. James W. Denny, Indianapolis, who spoke on "The Physician and the Medical Education Foundation."

A question and answer period followed.

Following presentation of the two guest speakers after the luncheon, Doctor Wright discussed "Problems of the 1955 State Legislature"; Dr. Eli Goodman, Charlestown, spoke on "The Health Council as a Public Relations Program," which he illustrated with a number of charts; Arthur P. Tiernan, Evansville, executive secretary of Vanderburgh County Medical Society, discussed "What the Medical Forum Can Do for Your Society," basing his statements on the outstanding results obtained by Vanderburgh County when the society joined with the Evansville Press to present a series of eight medical forums. Average attendance at each forum was 1,000 and a majority of the county's doctors actively participated in presenting the programs to the public.

Those at the speakers' table and special guests were introduced by Doctor Adler.

Concluding remarks before adjournment were made by James A. Waggener, executive secretary of I.S.M.A.

## WHERE ARE WE GOING WITH THE VOLUNTARY HEALTH PLANS?\*

WALTER L. PORTEUS, M.D.

*Franklin*

I SHOULD FIRST LIKE TO READ a definition of the term *insurance* to have a basic premise on which to start. The dictionary definition:—The act of insuring or assuring against loss or damage by a contingent event; a contract whereby for a stipulated consideration called a premium one party undertakes to indemnify or guarantee another against loss by a certain specified contingency or peril called a risk. The contract being set forth in a document called the policy; also the business of making such contracts.

This might also be put into another form to say that insurance may be defined as the pooling of relatively small regular premiums paid by or for a large number of persons subject to a serious hazard with the funds thus assembled being used to provide economic recompense for the relatively small number of persons who fall victims to that hazard. I would like for you to keep this definition in mind as related to the following discussion.

Voluntary health insurance does not provide medical service; only we physicians can do that. Through the insurance principle we provide against the economic hardships resulting from the cost of treating some illness by providing the money to reimburse a part or all the cost of such illness.

To begin a discussion of this subject I should like to preface my remarks by the introductory opening of an article by William Allen Richardson, the editor of *Medical Economics*, who said, "Voluntary health insurance in the United States has been called the greatest cooperative health effort in world history. It has developed at a

pace so rapid that those responsible for it have barely had time to keep up with it. But now we face the 'no-longer' postponable duty of taking stock, of asking ourselves perhaps for the first time since it all began, What are we really trying to accomplish? Why do we favor voluntary health insurance as the best means? Can it do the job? What's ahead for it?" Someone has said that the insurance mechanism is not a duplicating machine, turning out replicas of dollar bills received. Nor is it a multiplying machine which can change one dollar into two or three. The insurance mechanism can only distribute the dollars it gets. It can't provide medical services; all it can do is to distribute dollars to pay for those services.

A recent survey points up the enormity and rapidity of growth of this problem. It is very apparent when we find that 89,500,000 people in the United States own some type of health insurance. Compare this with 5,600,000 people who were protected in 1939. Fifty-seven per cent of the population or 87,400,000 people hold some type of hospitalization insurance. Forty-eight per cent of the population or 74,500,000 hold some form of surgical or medical coverage. This coverage has contributed to a tremendous increased usage of our hospitals with all the attendant problems. It bids fair to being a tremendous force in our government, our profession and to us as individual citizens.

We frequently talk of prepaid health insurance and prepaid medical care, but is it possible to prepay a totally unknown expense? The word prepayment often is unfortunately used because too often the consumer actually believes that he has prepaid something, so he tries to get his money's worth. It is impossible to prepay any type of insurance except as premiums are paid in advance—thus guaranteeing insurance for a

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\* Read before the 29th Annual Conference of County Medical Society Officers in the Student Union Building, Indiana University Medical Center, March 7, 1954.

period in the future. The only kind of prepayment the insurance mechanism is capable of recognizing is the payment of premiums in advance.

I have felt too often that many physicians believe voluntary health insurance was created for their own personal good. It was, however, a mechanism created for the patient to partially budget against the cost of illness and on our part an answer to compulsory government insurance or the socialization of medicine. In the short time allotted me I shall attempt to enumerate the various trends in the voluntary health insurance movement. These are not listed according to their importance and I hoped by bringing them to your attention it would start some thought-provoking discussion.

## I. LABOR:

The demands of labor for complete health security will have a profound effect upon this business of prepay insurance. When a large segment of our population gets prepay insurance by negotiations with management for the so-called fringe benefits it is useless to say these will have a terrific impact on both doctor-sponsored and commercial insurance plans.

A recent memorandum for 1954 collective bargaining in a C.I.O. paper gives the following points and reveals the scope of labor's demands. They are as follows:

1. Diagnostic and preventive medical care.
2. Payment of medical, dental, drug and appliance bills.
3. Payment of all hospital bills.
4. Increased life insurance, sick and accident benefits.
5. Decent pensions for the aged and permanently disabled.
6. Medical care program for retired and unemployed.
7. Rehabilitation program for the disabled.

The union workers are definitely insisting the so-called prepayment plan actually does prepay. They state they are quite in favor of fair and generous fees for physicians but find it difficult to understand why identical surgical procedures should cost them different amounts in different

parts of the country, and sometimes even in the same community. This sounds a bit like regimentation with the idea that all physicians are equally skilled in all types of work, which seems to be the public's opinion of our profession, thereby making it impossible for the better trained and skilled physician to charge more for his services. Their demand is for total service and not indemnity. Although I do not believe the term "service" can mean anything more than the money with which to supply the service. While you may not be in complete accord with the demands of labor, as consumers their desires cannot be passed off with a shrug of the shoulders.

## II. AGING POPULATION:

With our general population aging, the number of people 65 or older has increased three times the rate of increase in population for the whole United States since 1935. By 1980 if the present trend continues, one out of every eight Americans will be past the usual age of retirement. It is not difficult to see the impact this condition will have upon prepay insurance. Only about one out of ten commercial insurance companies will issue a new health policy regardless of the applicant's age. The fact that an estimated 60 percent of the men 65 or over and 92 percent of the women over 65 are unemployed poses a problem as to how they shall be able to pay premiums on any type of prepaid health insurance. The aging process brings a tendency for more severe and longer illnesses hence they become greater risks. Increasing numbers of oldsters in our country raises a definite problem from the political standpoint due to the weight of their vote. It has been suggested that each person be encouraged to pay for his own old age health protection during his working life time. He might be charged a higher premium than necessary during his most productive years so he would have a paid up policy by the time he retired. This of course, would not help those who are already retired and would create considerable administrative problems. However, it might be a means of returning to the idea of providing for your own future. Unless we physicians in cooperation with the insurance industry can come up with an answer to this problem I am not too sure but what Uncle Sam may step in and take it over as Mr. Ewing once suggested.



### III. DEDUCTIBLE OR CO-INSURANCE:

The opinion among many doctors and insurance men of today is if voluntary insurance is to prosper it has to be sold at a more reasonable cost. One method of obtaining this goal is by means of the deductible or so-called co-insurance basis with the patient participating in the cost of settling his claim so he will not abuse or over use his insurance. This being similar to the deductible automobile insurance in which the owner of a car assumes liability on a certain amount of the damage. This type of coverage would do away with many small claims, and the administrative costs thereto with a lessening of administrative overhead. It would make the patient feel that he is also interested in the usage of his own insurance. The co-insurance principle is also applicable to the next item to be discussed.

### IV. CATASTROPHIC COVERAGE:

Practically all commercial insurance companies now offer some form of catastrophic coverage employing the deductible or co-insurance factor. It means the policy pays, within certain limits, amounts above the deductions. In some instances the individual himself has to meet a proportion of the cost of insurance over and above the deductible amount. This in turn provides long range protection against certain specified catastrophic illnesses without a premium beyond the reach of the individual. Normal prepay insurance, as now sold, could be utilized to take care of the original deduction after which the larger policy would take over. This type of coverage as now offered seems reasonably low in cost considering the length of usage and the dollar limit. California, to date, I believe has had the most experience of any of the Blue Shield plans with this type of coverage.

### V. SERVICE VS. INDEMNITY:

Another dilemma facing the physicians sponsoring prepay plans such as Blue Shield is the question of service or indemnity types of insurance. Recently in California there has been a movement to put more emphasis on the indemnity type insurance and less on the service type coverage. Labor unions have already placed their stamp of approval on the service types of contract. The California committee working on

this project feels the patients will like it as well as the service contract if they are assured the indemnity payments will be high enough to be realistic and pay the approximate doctor's bill. Under the indemnity contract, the physician is always assured of receiving the indemnifying amount for any particular service. While under the service contract, the amount of money available for payment to the physician may be less than what he would normally charge.

In California they hope each physician will establish a fee schedule to be posted with his county society. Each county would then compile a list of average fees and from these averages would be drawn a statewide fee schedule. These state lists and county lists would be revised annually. It would be understood the physician would use this as a basis for charges unless he feels the service requires a larger fee, in which event he would be expected to work out an understanding with the patient in advance. This in itself is a good public relations angle. It would provide doctor-sponsored and commercial insurance carriers with realistic averages for use in drawing up indemnity schedules. A realistic indemnity schedule could virtually be a service contract in effect. Even the existing service contracts become indemnity contracts to families with an income level above a predetermined amount.

Many physicians in our own state have objected to a service contract because of the fact that they felt they would be unable to charge a just fee for cases which required longer and more skilled attention. An indemnity contract with a fee schedule varying from year to year in proportion to general living costs would certainly be more acceptable to physicians and patients alike. The question in California has been asked will the average fee listed with the state and county society then become a maximum fee. Dr. Wilbur Bailey, chairman of the CMA committee, in discussing his average fee system believes that the following four points might be effected:

1. It will let the patient know in advance the cost of medical procedures.
2. It will serve as a barrier to those who are bringing compulsory health insurance upon the profession.
3. It will supplant the Blue Shield Service

type plan which has been criticized by doctors and patients alike in many areas.

4. It will help Blue Shield and private insurance carriers to compete on more even terms with the closed panel plans such as Permanente.

It is questionable from an insurance principle point of view that prepay medical insurance can be on a very sound basis until all of it is of the indemnity type in which payment made by the insuring companies is intended to cover only part of the medical bill. It is true that a majority of Blue Shield and all of Blue Cross plans are now on the service contract. The California Plan is merely a trend.

#### **VI. TAX EXEMPTIONS FOR PREMIUMS TO PREPAY INSURANCE:**

There is increasing pressure for changes in the income tax laws to permit deduction of premiums of prepaid insurance. This would probably be the greatest asset in increasing the number of people covered. For prepayment insurance to do a thorough job it must reach the greatest number of our people. The deduction of the premium from income taxes would certainly be a valuable aid in selling those who are not now reached. This feature alone would remove the compulsory aspects of governmental insurance and would result in many people buying insurance who otherwise would not be able to afford it. If employers are permitted to deduct as a business expense the voluntary health insurance premium they pay to their employees it would only seem fair for the government to permit the same deductions to individuals who pay their own premiums.

#### **VII. MORE MEDICAL COVERAGE IN PREPAY POLICIES:**

Another trend in the voluntary insurance field is the placing of more emphasis upon skilled medical care in relation to the surgical treatment as is now covered. It is generally agreed that acute medical emergencies such as diabetic coma, coronary disease, etc., are quite time-consuming and just as expensive to the patient with little or no coverage as far as insurance plans are concerned. Along with the medical men's desire for some increasing indemnity we have the anesthesiologists and in some instances the roentgenologists and pathologists wanting a

place in the program from the doctor side rather than the hospital. These moves in themselves may produce changes in rates and certain physician-hospital relationships.

#### **VIII. HOME AND OFFICE CARE:**

Home and office care has been discussed possibly as being covered by prepayment insurance plans. However, in most instances this could result in many small claims being presented to the company with large administrative costs. Prepay insurance, primarily is intended to take care of the more catastrophic or expensive types of illness. It is felt the patient is better able to take care of the small bill himself. However, do not forget labor's demand for an all-inclusive health set up which would imply home and office coverage. Addition of these services to any contract tends to increase the premium rate to the point where it may price the plan out of the field. I believe our own experience in this field in pilot studies has shown the utilization to be quite small.

#### **IX. GOOD AND BAD CONTRACTS:**

As Jimmy Durante says, "Everyone is trying to get in the act." With such a fertile field it is no wonder there are so many companies entering the prepay health insurance business. While most are operated on a high ethical plane a few are not. Some companies return a relatively small amount of the premium dollar to the subscriber and use every dodge to avoid payment of claims. They also use the cancellation feature to avoid further liability. This creates disgruntled policy holders who then become advocates of government insurance. I would predict in the future there will be more government investigation of insurance companies who pay very little or by virtue of the small print escape their obligations to the subscriber. Companies of this sort are detrimental to the well-being of any prepay insurance.

#### **X. REINSURANCE:**

The question of reinsurance as advocated by the present administration in Washington is still in a nebulous state. The principle is old in the insurance game. I understand insurance experts have turned a cold eye on the proposition as proposed by the government. To be a success

financially it should stand on its own feet and not be subsidized by tax dollars.

## **XI. IN GENERAL:**

There are those who say that prepay insurance is a fair weather proposition and when a depression comes it will melt away. I believe it is here to stay in some form or another. I further believe that when an individual or a company seeks to sell a product or a service he must have public demand. So you must have an acceptable saleable product for those who buy it. Again, prepay insurance is not wholly for physicians or their benefits. We merely enjoy the advantages of its use by our patients.

## **XII. THE USE AND ABUSES OF PREPAID INSURANCE:**

No discussion of prepay medical care plans would be complete without something being said about the use and abuse of such plans. It has been said that the chiselers are in the minority, that unintentional abuse is causing the most damage and is even bringing voluntary health insurance to the brink of financial ruin. A recent article by Ralph J. Walker, vice-president of the Pacific Mutual Life Insurance Company of Los Angeles, said "all health insurance mechanisms have suffered from an excess of cooperation on the part of hospitals and doctors who want to get the most for their patients out of health insurance. Many of them don't realize that the only proper source of money with which to pay benefits is the consumer's own pocket." The abuses might be listed as the following:

1. Unnecessary hospitalization: This abuse varies with the area and the doctor's conscience

and the pressure of patient demand. It is in this area we have the philosophy of "over co-operation."

2. Keeping the patient in the hospital too long: This item alone costs the insurance industry millions of dollars a year and has to be reflected in premiums.

3. Excessive laboratory and x-ray tests: Attempts to impress the patient or your colleagues as to your thoroughness again adds to the cost of hospital care.

4. Over-medication: I have seen patients get one shot of liver extract—surely, if needed one was not enough. Expensive antibiotics have been used for everything from dandruff to fallen arches. Again all unnecessary cost.

5. Patients put in the hospital on the pretense of treatment when it is mainly for diagnosis: There is plenty of room for argument on this item but often the original diagnosis is not too clear and the patient is admitted and has the "works" for many unrelated conditions.

6. Increase in charges: There have been instances where physicians would increase their fees simply because the patient had prepay medical care insurance. This was done when the payment already approximated his normal fee. Another shortsighted trick is to charge a large fee and condemn the insurance company for not paying in full. Most of these ills could be obviated by prior discussion of fees.

It has been said that we will always have our quota of those with myopic vision and a large overhead. This in turn is definitely sabotage to the profession's answer to government medicine.



## WHAT'S HAPPENING TO MALPRACTICE INSURANCE RATES?

DON C. HAWKINS\*

*St. Paul, Minnesota*

I WAS VERY HAPPY to accept the invitation to talk to this group, and I will try to give you at least some of the reasons why there has been an increase in premiums and tell you some of the problems which confront ourselves as well as some of the other companies. You may have a general idea, but have given no serious consideration to the problem. Whatever has been your attitude or your interest, the situation is extremely unfavorable and deserves your immediate attention.

As I began to assemble my notes for this talk and realized it was to be my lot to speak rather frankly and at times critically about some economic facts that involve our very survival as a free industry, I was reminded of an amusingly practical epitaph on a weather-beaten old tombstone in a remote Southern graveyard, which went something like this:

"Here lie I, Martin Elginrod.  
Have mercy on my soul, Lord God.  
As I wad do, were I Lord God,  
And ye were Martin Elginrod."

I imagine my feelings today here in Indianapolis must be somewhat similar to those of poor Martin Elginrod when he realistically looked the facts of life in the face and had chiselled in stone his homespun plea for fair play at the throne of final judgment. I, too, on behalf of the companies for which I speak, stand before a throne of judgment, and hope to chisel in your common conscience my own plea for fair play.

In presenting facts, I need not confine my remarks to this meeting alone, though its importance is not to be minimized. The story, as I see it, is national in scope. Therefore, I am speaking beyond the confines of this room and submitting my case to the country as a whole. It

is a case of what is happening to the casualty industry and the hospital and professional picture in particular, which today finds itself caught in a multi-sided squeeze of inflation, rising accident tolls, public misunderstanding, political pressures, socialistic trends, excessive claims and inadequate rates—which, you must admit, is quite a squeeze. In these days of mass pressure groups and glorification of socialism or its equivalent in softer language, gold medals are not being pinned on business, industry or the medical profession for their magnificent achievement in building upon this continent a standard of living and economic system that has no equal in all history. If they were, surely the insurance business and the medical profession would be entitled to one for the miracle that has been performed at a time when the prices for almost everything have ascended to unprecedented heights. To become specific about liability and malpractice insurance, which has become a dilemma, this is where the red ink really begins to flow.

In your state, a plan was organized in 1946. In 1952 there were only \$21,543 in premiums and \$10,744 in losses. In 1953 there were \$48,198 in premiums and \$70,029 in losses. However, over the period of 1946 to 1953 there were \$172,140 in premiums and \$149,858 in losses, with a loss ratio of over 90%. The insurance companies, unlike most other businesses and industrial enterprises, are not permitted to increase their rates at will to meet rising costs of doing business. We have long been regulated by state governments, and the rates, that is sale price, must stand the test of governmental approval. Therefore, confronted by rapidly increased losses with no prospect of improvement in the foreseeable future, new rates were filed with the respective state supervisory authorities in the hope that they would be sufficient to take

\* Mr. Hawkins is with the St. Paul Mercury Indemnity Company.

# now—income\*

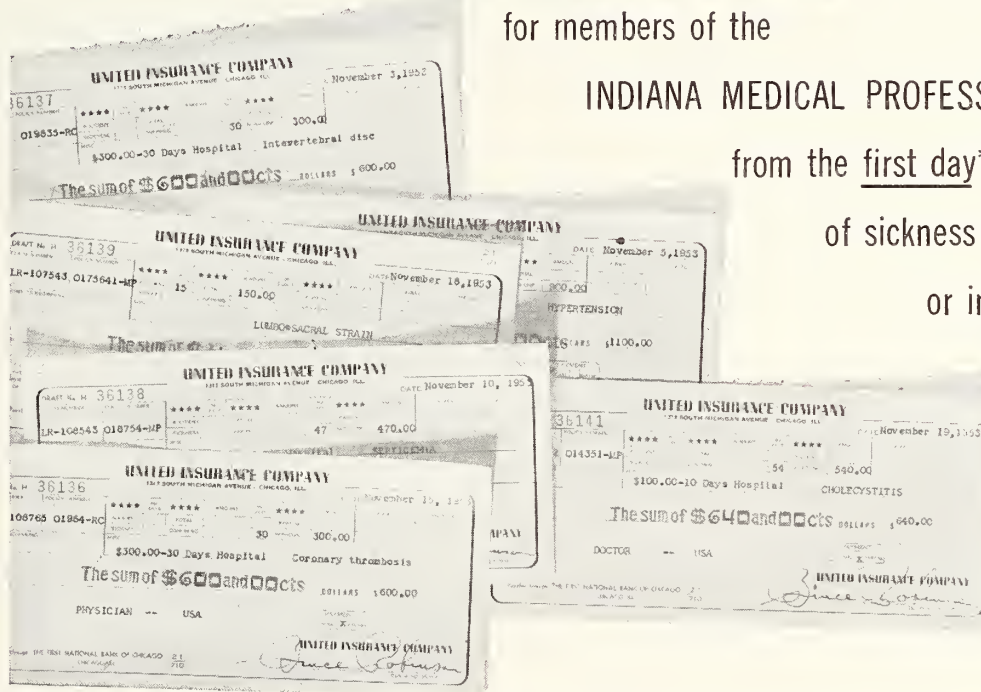
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us out of the red and allow a small margin of profit.

One might suppose from facts and figures, all of which are a matter of public record and readily available for confirmation, that there would be no question about being granted the increases to earn at least a small profit. On the whole, I believe state supervisory authorities are inclined to grant some increases—at least enough to improve the situation. I would like you and the public everywhere to decide whether the problems are products of mismanagement within our industry, or developments on the outside and completely beyond our control, but easily within the control of an informed and aroused public.

In the first place, when government regulates a business, it demands mathematical proof of the need for price increases and, before its approval is forthcoming, it takes a minimum of a year and frequently more for insurance statistics to catch up with conditions.

#### Inflation Upset Calculations

What the casualty insurance companies did not and could not foresee were two events that

were to upset the calculations of the nation's soundest economists, and you will recall that economists everywhere expected a business recession back in the months immediately following the second World War. In fact, the outlines of a recession actually began to take form. Then our country's program for vast financial aid to Europe developed, and the stage was set for inflation. Then the second blow fell. Almost overnight we found ourselves at war in Korea, and inflation became rampant. Traffic accidents increased at a shocking rate. Prices for literally everything skyrocketed. Court awards for damage claims followed and even exceeded the rise in general prices. Claim costs rose to an unprecedented level in 1951, confronted by losses that were to exceed \$100,000,000.

Now let us see whether the prices of liability insurance were out of line with other commodities and services. Since 1939 the commodities price index had increased approximately 89%. For the same period, hospital expenses had soared 135%, automobile repair costs 134%, the prices of new automobiles 136%, the cost of settling claims has increased 150% for property damage and 70% for bodily injury, and in the



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1. Cowart, E. C., Jr.: Mississippi Doctor 29:278 (April) 1952.
2. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (March) 1951.
3. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.
4. Trafton, H. M., and Lind, H. E.: J. Urol. 69:315 (Feb.) 1953.



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same period of time liability insurance has increased an average of 35%. In other words, everything that affects the price of liability insurance has increased considerably more than the price of insurance itself.

Now for a quick comparison with other products. The average retail price of food products rose 142%, while individual items in the market basket, like fish, beef and veal, went up 240 to 247%, respectively. The figures that have been cited are national averages, but I am sure they apply generally in Indiana.

These comparisons are not picked from the top of the price list just to make our position look better than it is. Naturally, prices of certain commodities and services have been selected that very directly influence and to a large extent control claim costs. The others, however, are prices with which every family budget is all too familiar, and it stands to reason that the insurance family budgets are no exception to the rule.

Surely no fair-minded person will deny that insurance companies have done more to hold the price line than the great majority of other industrial and business enterprises.

What some of you may not know is that a year or so ago, in Houston, Texas, there was a convention of the National Association of Claimants' Attorneys, and the impression the members of this association wish to convey is that they operate as a public service. The attempt to convey this impression is laudable, but when we reckon with the service performed we must take into account a record in the courts which is second to none in history. If we are asking for tinder for the flame of inflation, we have it here.

You know, as well as I, that verdicts of shocking proportions are being handed down by juries today. Is this in the public's interest? Is an organized attempt to employ every trick in the legal book to gain ever increasing judgments a public service?

This association to which I refer was founded some six years ago, and its membership, by its own statement, is limited to lawyers helping injured workers. However, the group has extended its interest to include bodily injury cases involving almost everyone, whether a worker or not, arising out of any accident, whether on the job or not, regardless of where or how it occurs.

We in the insurance business are not averse

to organization within trades, professions or industry, but we do believe that every such organization should always practice a high standard of ethics and a statesmanlike measure of fairness. Comments by members, therefore, on important matters of public interest should certainly reflect an understanding of all the facts. More than that, such facts should be expressed. Frankly, I could find neither ethics nor fairness nor an expression of the facts in the comments of some of the spokesmen at the convention to which I referred. Some of the speakers were wont to criticize insurance companies from almost every conceivable angle. They spoke frequently of dishonest adjusters while neglecting to mention that insurance companies are closely scrutinized by Insurance Departments and the public, so that it is impossible to successfully partake in dishonest practices. They did say, however, that companies do not pay their just debts. The NACCA speakers made no reference to the fact that in 1951 casualty insurance companies paid out \$100 million more than they took in because they did meet their obligations. The members of this organization deal almost exclusively with casualty companies and are well aware that the profits of other carriers are not concerned with the losses sustained by the casualty companies, and we believe that their statement was for the purpose of influencing uninformed members of the public and to create publicity averse to the insurance industry.

To understand their position we must realize that juries are inclined to base the size of a plaintiff's award upon the defendant's ability to pay. Therefore, by building general antagonism against insurance companies, while at the same time picturing them as tremendously wealthy, the chance of obtaining higher awards is considerably greater.

How big a piece of the juicy melon do the casualty insurance companies get? There is a strange belief abroad that somehow, somewhere, insurance companies have miraculously tapped an inexhaustible well from which dollars flow in endless supply and that, therefore, an insurance company is fair game whenever the opportunity is presented to hand out an economic shellacking.

I have already shown that 1951 was a year of net loss, but let's look at the underwriting profit for a substantial number of years. During the

20-year period from 1931 to 1950 the underwriting profit on all lines written by member companies of the National Bureau of Casualty Underwriters averaged—what do you think?—6%? Far from it. 3%? No. 1%? Still too high. It was 7/10 of 1%. I wish everyone in the United States knew that. If they did, our rating problems would be about over. What is more, that little 7/10 of 1% profit was before paying Federal income taxes.

Who will benefit from the National Association of Claimants' Attorneys? It cannot be the insurance companies, for although the continuation of excessive court awards will force many people to purchase insurance in self-defense, it will also raise rates to the degree that other people who need insurance will not be able to buy it. The general public will not benefit. Although the attorneys have chalked up a record for high awards to claimants, we must consider that frequently the attorney's fees amount to 40% of the awards. Simple arithmetic tells us that before a claimant actually profits under these circumstances awards must be 166⅔% of what would normally be received. The only real beneficiaries are its member attorneys, for here, as we see it, is the only real purpose of the organization. As long as their fees are from 33⅓% to 40% of the take, claimants' attorneys will profit from high awards. They will continue to receive amounts almost as great as claimants they propose to help while sustaining no injuries and suffering no pain themselves.

I am not going to take up your time and contrast that margin of profit with the profits of other industries and business enterprises, and I would like it to be understood that I imply not the slightest criticism in any instance. What I do say, however, is that without insurance none of them would exist, and what we do, no one can do better, and I exclude no group or federal or state agency.

I have been talking about over-all problems

which cause increased premiums, and tried to indicate that the situation is extremely unfavorable and deserves your immediate attention.

Ignorance on the part of the medical profession about this important subject is disturbingly evident in spite of effort of insurance companies to bring the matter to their attention. It is also evident that there is a lack of understanding in what the insurance does for the profession as a whole or how it protects against ruinous losses unless they, as individuals, are faced with such a claim or suit. Many have no idea how the rates (premiums) are promulgated. Few understand that the premiums must cover expenses as well as claims, and as a result believe the insurance companies make fantastic profits. This belief is shared by the same people who believe that all doctors are rich. In the light of these misunderstandings, it is easy to understand why some people support legislative proposals to place automobile liability insurance, workmen's compensation, health insurance and other casualty insurance under monopolistic state funds and governmental control. It also becomes easy to understand why juries hand out large awards today. Other contributing factors are—judgments and expense items are paid in terms of inflated dollars. The juryman who pays \$2,500 for a low-priced automobile and \$1.50 for a

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The medical practice itself has not escaped social evolution. The personal relationship between the physician and the patient has practically disappeared and has been replaced by group practice, clinic and partnership, so that the patient does not—except on rare occasions—consult the same physician. This may be good medicine, but it has certainly eliminated some of the warm, personal family physician relationship that once existed, plus the fact that the increased use of the hospital has taken an even larger segment of medical practice out of the home and office.

Claims originate in many and divers ways—physicians criticizing others' methods and treatment results, divulging facts about a case or ailment to others, improper diagnosis, improper treatment, and the ever-present fictitious case or hypothetical case.

The methods of correcting the situation are known. Everyone should ask these questions:

Do I follow the rules of my profession?

Do I follow honest and safe practices?

Do I realize that insurance companies are subject to the same economic pressures as my own?

Are claims morally and legally honest?

Are insurance costs in line with my own, considering current conditions, and not conditions of 20 years ago?

Have I opposed socialization of the insurance industry, as I have my own business, remembering when socialism gets its foot in the door in one important branch of the free enterprise system, it would soon be in the door altogether?

In answer to these questions, you will find the causes for the rising insurance rates.

I do not wish to be misunderstood as to the objectives of your Insurance Committee, because I think the work that has been done is commendable and certainly the efforts of Al Stump have had a vital effect on our experience in Indiana.

I realize, as you do, that this is not an easy

problem to solve, but neither is any effective program. Your committee can tell you there is a very limited number of companies still interested in this business who can render a real service. At the moment we are, but we need more members in the program. Today there are only about 400 in the plan, which, I suppose, is less than 10% of the total membership.

My case before the court of public opinion is completed. I could go on and particularize, but there is neither the time nor, I hope, the necessity to do so. I am content to rest on the record. I plead that only those who judge the industry of which I speak shall ask themselves these questions before they oppose adjustment in the rates for their insurance. With respect to the liability insurance—are the insurance companies subject to the same pressure of inflation as my business? Have I stood firmly for fair jury awards in injury cases and as firmly against excessive awards in such cases, remembering that my neighbors and I largely make my own insurance rates?

When the aggregate of all our judges can honestly answer all these questions in the affirmative, we will have less to worry about with respect to the cost of insurance.

We in the insurance industry will do our part. We will do our utmost to keep the public informed. We will conduct our business soundly, economically, and in the public interest. We will do our utmost to keep rates down and to reduce them as quickly as the mathematics of claim costs and the cost of doing business permit, but I would be less than honest if I did not say to you that we cannot do this job alone. Only the mighty force of aroused and enlightened public opinion can reduce accidents. Only the conscience of the individual claimant can make the aggregate of claims honest. Only the realization of the individual juror that he is spending his own money and not the money of insurance companies will prevent excessive jury awards. I can only tell you that until these reforms are put in motion, the casualty insurance companies have no choice but to ask for rates that are fair in the light of conditions as they exist, so in the words of Martin Elginrod, I say to our judges, "Do unto us as you would have us do unto you."

## SUMMARIZED REPORT MADE OF NINTH NATIONAL CONFERENCE ON RURAL HEALTH

Dr. Joseph E. Dudding, Hope, chairman of the Committee on Rural Health of the Indiana State Medical Association, represented his committee and the Association at the Dallas conference.

**R**AIN, SLEET and fluffy wet snow shattered an expected record attendance at the ninth National Conference on Rural Health, sponsored by the Council on Rural Health of the American Medical Association at Dallas, Texas, March 4-5-6.

With heavy snow storms blocking nearly all transportation from the north and east, more than 40 reservations were cancelled by wire on the opening day of the meeting. Scores of other farm health leaders, who had made advance reservations by mail, failed to show. But despite the bad weather, the total registration was 550, only 100 less than were registered at last year's meeting in Roanoke, Va.

The program itself, which covered a wide variety of rural health problems, was especially interesting because more time at both morning and afternoon sessions was devoted to questions and answers from the floor and to panel discussions.

From these hours of discussion one point became crystal clear: the medical profession and farm leaders now possess a unity of purpose and performance in stimulating rural people to attain a fuller and more healthful life.

Several speakers stressed the fact that medicine is no longer a job for the doctor alone—it's a problem for the community. In fact, the health of the community, as the speakers pointed out, is part of the duty of the community itself.

Dr. George F. Lull, Chicago, secretary and general manager of the American Medical Association, said in opening the meeting:

"Public health facilities must be extended to cover all areas so that there will be universal protection against communicable diseases, protection of food, milk and water supplies, elimina-

tion of disease-bearing insects, and adequate environmental sanitation. The American Medical Association, built on a record of public service over a period of 107 years, is interested in all of these problems and their solutions. Any help which you rural health people can extend in doing the job will be most appreciated."

### Why They Attend Rural Health Meetings

Why do so many people attend the American Medical Association's Rural Health meetings year after year?

Interviews with some of these farm health leaders at Dallas revealed that the sessions provide an ideal proving-ground for the exchange of ideas on problems as they exist in various sections of the country.

Mrs. Maggie Brown, Marshfield, Missouri, president of the Webster County Health Council, who has attended five of the nine A.M.A. meetings, said:

"I need the information which I get at these meetings to take back to health people in the Ozark hills of Missouri. I condense a report for those people in 32 Missouri counties. The meetings pinpoint the health needs in rural areas all over the country and the information is most enlightening to me."

Said Mrs. Edith Bangham, Madison, Wisconsin, president of the Wisconsin Public Health Council, who has attended all of the nine meetings held so far:

"These meetings provide me with new ideas on what is happening in organization and new trends in health insurance and nutrition. I'm here because I want to meet with other leaders in this field, hear what they are doing, coordinate

our ideas and problems, and then discuss possible solutions."

Chester Starr, Jefferson City, Missouri, a representative of the Missouri Farm Bureau Federation, who has attended eight of the nine meetings, said:

"We want to do everything we can in Missouri to better health conditions for the farmer. We found at the first few meetings that there was misunderstanding between physicians and the farm people. This created an air of suspicion and antagonism. The turbulence soon disappeared as each group began to understand the other's problems. Now there is a good working relationship for the common interest in creating better health conditions for farm people everywhere."

Dr. M. C. Wiginton, Hammon, Louisiana, president of the Louisiana Health Council, who attended eight meetings, said:

"I'm vitally interested in what people are doing to improve the health of rural America. I think these meetings have shown consistently how farm and health people, working together with a common interest, can solve problems beneficial to all."

Said Miss Helen Becker, of the Agricultural Extension Service of the College of Agriculture, Lincoln, Nebraska, who has attended eight of the nine sessions:

"I am in the educational field. I think educators and doctors should work together for better understanding of the health needs of rural people. There is a great deal that the medical profession can do for educators in giving a background of understanding and, in turn, the educators want to give to rural people a better understanding of medical care problems."

Dr. Robert N. Barr, Minneapolis, deputy state health officer for Minnesota, who has attended all nine meetings, said:

"These conferences afford an ideal opportunity for an interchange of ideas with other state representatives. We can learn what they are doing and weigh the results of their effort. This builds up our knowledge for better health plans within our own state."

#### **Applaud Dr. McCormick's Speech**

Dr. Edward J. McCormick, president of the American Medical Association, delivered an

inspiring address and was showered with applause at its conclusion.

He struck a happy chord when he said that rural people are setting an example of self-reliance that should be adopted by all Americans.

Calling for a restoration of the independent spirit "which has made America great," the Toledo, Ohio, surgeon cited some of the work done to improve medical care in farm communities.

"You have certainly put the 'U' in community," Dr. McCormick said. "We all hope that cooperation between the medical profession and the rural groups will continue until every rural area in our great country is supplied with the best that medicine can give.

"One of the most important activities in which the American Medical Association and its Council on Rural Health has engaged is the physician's placement program. We can point with pride to the many rural communities which have a physician and good medical care. The experience in Texas and in Kansas and in many other states is evidence that this program is working and that it will continue to expand.

"Many medical organizations are awarding scholarships to young men and women who will practice in rural areas. The deans of many of our medical schools are stressing the importance of rural health."

The A.M.A. president urged rural folks not to forget the local doctors, whom they worked so hard to get, because modern transportation has made it so easy to by-pass the doctor in the small community.

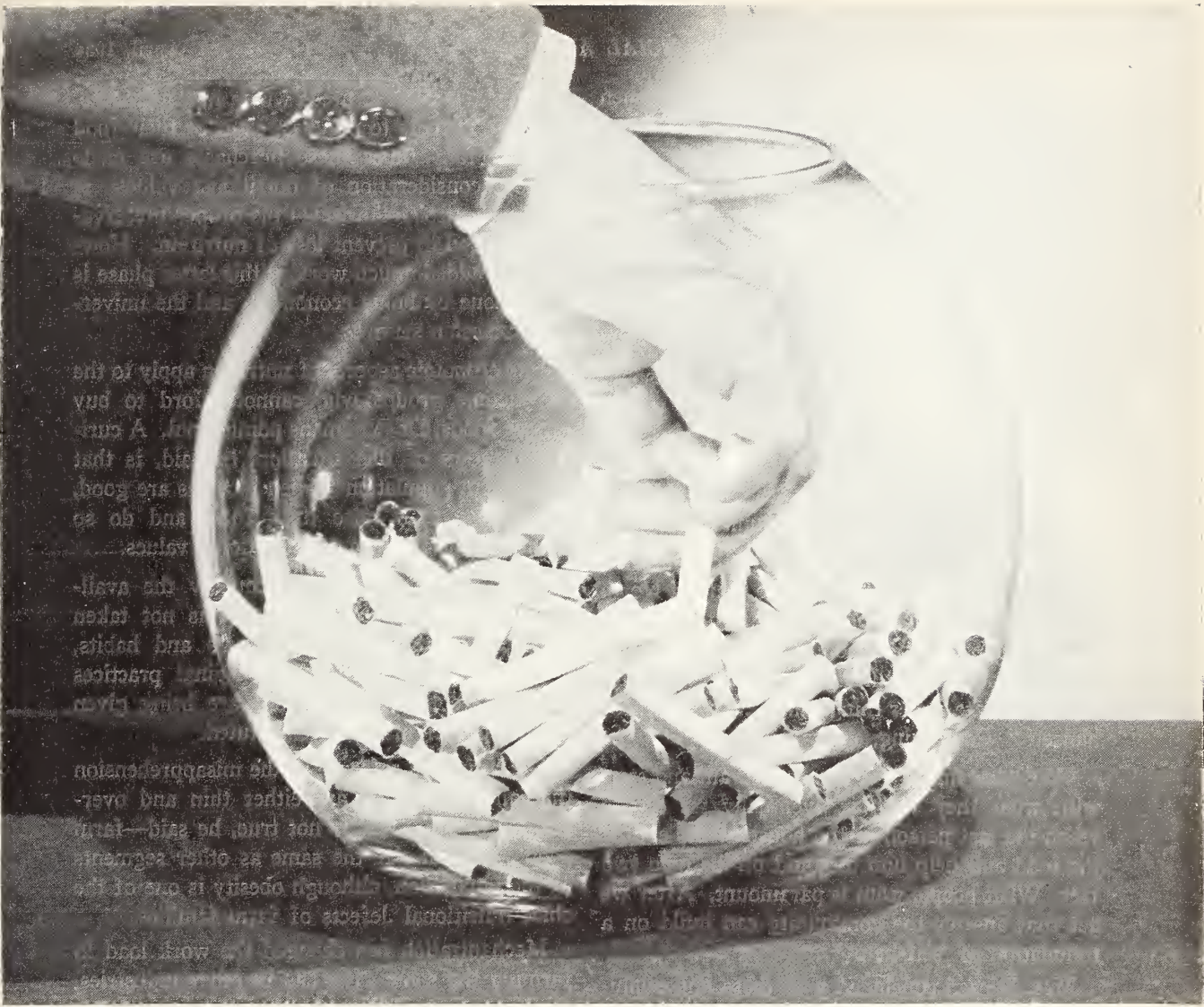
"I recognize in the rural people a progressive and conservative and intelligent group," Dr. McCormick said. "I know that you are independent and truly American, that you are willing to provide not only for yourselves but that from your land you have been providing for most of the world.

"It is the spirit of independence and the dislike of dole which has made America a great and a strong nation. Rural people are self-reliant and all Americans should be so if we expect to preserve our freedom."

#### **Sets Theme for Conference**

Dr. McCormick's fellow citizen, Dr. Carl S. Mundy, Toledo, acting chairman of the A.M.A. Council on Rural Health, sounded the theme—





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"We believe that maintenance of health is, to a large extent, the responsibility of the individual and to a lesser extent the responsibility of his community. It is an individual's responsibility, acting collectively with others, to see to it that proper health measures are in force. Therefore, it follows that the health of a community is, in the last analysis, the responsibility of each individual in that community."

Charlotte Rickman Bensen, health education consultant, Medical Society of the State of North Carolina at Raleigh, told the group that "there is nothing quite so important to health as the self-esteem earned through an individual's efforts to create better things and better health for himself." Continuing, she said:

"We must find out what people want and start with what they want if eventually we are to reach the last person in the house at the end of the road and help him to stand on his own two feet. What people want is paramount. After we get that answer the community can build on a foundation of 'self-help'."

Mrs. Bensen concluded with these philosophical observations based on working experience:

"No two counties are alike . . . the problems are different just as the people are different; health cannot be separated from agriculture, recreation, business or family living; we can't give people all the answers . . . they have their own solutions and ways of solving problems; faith in people's ability to do for themselves is the most important single ingredient for promoting community programs; democracy, like health education, is a slow process . . . there are no quick, sure-fire methods or patterns."

#### **How Nutrition Affects Farm Families**

Dr. John B. Youmans, Nashville, Tennessee, gave an excellent talk on nutritional problems of farm families which, he said, are based on three factors—geography, economics, and customs and habits.

Dr. Youmans, who is dean of the Vanderbilt University School of Medicine, said that some

farms are located in areas which make it necessary for farmers to purchase most of their food stuffs. Many times these purchases are made without consideration of nutritional values. A problem in isolated areas is the proper preservation of food to prevent loss of nutrition. However, he added, much work in this latter phase is being done by home economists and the university extension services.

The economic aspects of nutrition apply to the low-income groups who cannot afford to buy proper foods, Dr. Youmans pointed out. A curious paradox of this situation, he said, is that some farm populations, when incomes are good, buy rather than raise their food, and do so without consideration of nutritional values.

In some sections of the country the availability of food of better quality is not taken advantage of because of customs and habits, he stated. Paradoxically, original practices which were health protections are being given up and poorer practices substituted.

Dr. Youmans referred to the misapprehension that all farm wives are either thin and overworked or fat. This is not true, he said—farm people vary in size the same as other segments of the population, although obesity is one of the chief nutritional defects of farm families.

Mechanization has changed the work load in farming the same as it has in other industries, so that the need for calories and energy foods is less, Dr. Youmans added. Although farming still remains what is considered a heavy occupation, mechanization and the resultant shortened work hours have reduced food requirements—a fact to which many farmers have not acclimated themselves.

Dr. Youmans stressed the need for everyone to be able to recognize good nutrition. Proper nutrition can be obtained, he said, not by adding more and more nutrients to the diet, but by obtaining the right amounts of all nutrients and vitamins.

#### **Texas Solves Doctor Distribution**

Another interesting talk at the conference outlined how Texas solved its doctor distribution problem.

Dr. Chester U. Callan, Rotan, Texas, chairman of the Texas Medical Association's rural health committee, said 38 family doctors were



placed in rural Texas communities last year, and that the state association has a list of 60 general practitioners seeking locations and 64 others who will be available in coming months. Requests for physicians from 44 small communities are on file and under consideration.

Dr. Callan stated that the medical profession in Texas, faced with the problem of serving a vast geographical area, with many counties having a very small population, undertook in 1952 to investigate the situation and correct conditions.

First, questionnaires were sent to about 6,500 doctors, asking them to provide information on the location of physicians by population, the type of practice, amount of time spent in practice, hospital facilities, the need for additional doctors and other data. About 6,000 replied, giving the basis for further investigation.

Next, communities were contacted in order to determine if they felt a need for additional physicians. Local doctors and county medical societies were advised of these moves and they cooperated.

In contacting communities, it was stressed that keeping a doctor is the joint responsibility of the doctor and of the community. Local officials were informed of what was generally required by physicians in the way of patients, medical care facilities, housing, schools, and churches.

"If the need is clearly shown to exist, it then becomes the job of our placement service to explore all possible sources, and to bend every effort possible toward getting a doctor to the community as quickly as possible," he reported.

"Generally speaking, we think the conditions regarding doctor distribution in Texas are healthy. The ratio of doctors to population in our state is below that of the United States.

However, it is improving in that doctors are coming to Texas more rapidly than to other areas of the country. We have one doctor per 813 population in Texas."

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## Symposium on Thoracic Diseases Held March 4 at Lafayette

Another in the series of symposiums presented by the Indiana Trudeau Society in cooperation with the Indiana Chapter of the American College of Chest Physicians was held at Lincoln Lodge, Lafayette, March 4.

Local arrangements were made by Drs. Joseph W. Strayer and Ramon B. DuBois.

Participating in the programs were Dr. Edward W. Custer, South Bend; Dr. Stuart R. Combs, Terre Haute; Dr. J. W. Strayer, Lafayette; and Drs. L. W. Spolyar, Warren S. Tucker, Donald W. Brodie, J. K. Berman, Edwin R. Eaton, James H. Stygall, John V. Thompson and Chester W. Stayton, Jr., all of Indianapolis.

Another symposium was scheduled for Richmond during the month of April.

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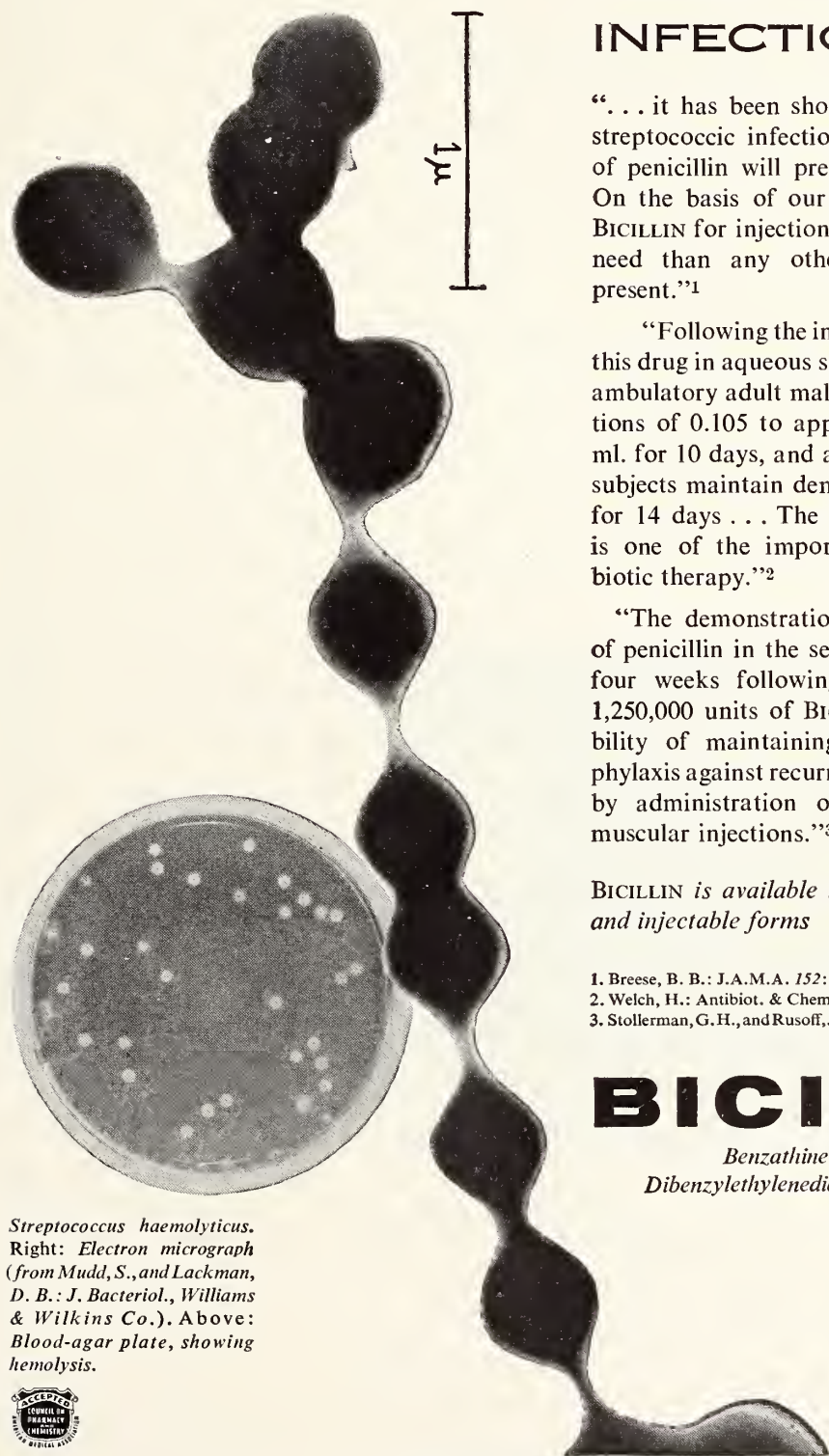
1. Breese, B. B.: J.A.M.A. 152:10 (May 2) 1953

2. Welch, H.: Antibiot. & Chemo. 3:347 (April) 1953

3. Stollerman, G.H., and Rusoff, J.H.: J.A.M.A. 150:1571 (Dec. 20) 1952

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& Wilkins Co.). Above:  
Blood-agar plate, showing  
hemolysis.



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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

## THE MONTH IN WASHINGTON

Washington, D. C.—Just about a year ago the Hill-Burton hospital construction program was under heavy attack in the House Appropriations Committee. But the damage was not permanent. The program has made a complete recovery. More than that, Congress shows every intention of doubling the appropriation for the program, but earmarking the additional money for grants to diagnostic and treatment centers, rehabilitation facilities, hospitals for the chronically ill, and nursing homes. At this stage the legislation to stimulate health facility construction is believed to be closer to enactment than any

other major health project of the Eisenhower administration. Although the main objectives have not been altered, some significant changes were made in the bill by the House Interstate and Foreign Commerce Committee in two weeks of intensive work at closed-door sessions. Then, in mid-March, the Senate committee took up the bill and considered additional amendments.

Most changes are designed to tighten up eligibility for grants. For example, money could go to only two types of diagnostic or treatment centers, those operated by and for a governmental unit or by a group that also



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operates a nonprofit hospital. Nor would centers or nursing homes be eligible unless under medical supervision or operated by an association that also operates a hospital.

Another change written into the bill would rule out a project if it were not to be open for full and unrestricted use by the general public. Thus labor union, fraternal, and prepayment health plans could not benefit if they offered their own subscribers any advantage in service at the center or hospital.

On the financial side, several amendments have been tentatively adopted. One would allow states to use the original Hill-Burton formula for apportioning money among projects, or to accept a flat 50 percent federal contribution. (As in the original Hill-Burton act, the poorer states would be allocated more per capita.) States would be allowed to pool their allocations for construction of interstate facilities, and the United States would be authorized to recover its proportionate share of a project if at any time the project were converted to profit use or were transferred to interests which for any other reason would not be eligible.

Of major interest to the medical profession, although not far along on its legislative course, is the administration's proposal for subsidizing prepaid health plans for federal civilian employees. The U. S. would pay a maximum of \$26 per year, to be matched by the employee, for the purchase of any type of prepaid insurance. Any cost above \$52 per year would have to be borne entirely by the employee.

As a part of the program, the administration is proposing that payroll deductions be authorized, a concession the insurance and prepayment insurance organizations have been urging for years. Currently federal executives differ on whether payroll deductions would be "legal," but none is willing to risk authorizing deductions in the absence of specific approval from Congress.

Still following a slow and controversial course is the administration's proposal for reinsurance of health plans. Early in the session—with the ardent support of Chairman Charles S. Wolverton of the key House committee—this legislation appeared pointed toward enactment. However, the Department

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of Health, Education, and Welfare was not satisfied with Mr. Wolverton's bill and decided to draft one of its own. The drafting consumed many weeks—time that may prove fatal with a Congress hoping to adjourn early for the fall elections.

The Defense Department, made uncomfortable by a few suspected subversive physicians and dentists it doesn't quite know what to do with, is asking for an amendment to the Doctor Draft act. The department's problem is this: The most recent Court of Appeals decision holds that physicians or dentists drafted or called up from the reserves must, under the Doctor Draft act, either be commissioned or discharged. So, technically, a man who refuses to fill out his loyalty questionnaire would be rewarded by a release. To correct the situation, the Department is asking that the law be changed to allow it to withhold a commission from a loyalty suspect, yet keep him on duty for the specified time in noncommissioned status and assigned to professional duties.

The American Medical Association is continuing its support of Senator Bricker and

others who are convinced they still can enact a resolution calling for an amendment to restrict international agreements. The Association's position is that unless a safeguard is written into the Constitution, future international agreements could impose on the country social and medical care programs that Congress itself would not approve.



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## Deaths . . .

**Homer Benjamin Gable, M.D.**, practicing physician in Monticello for 44 years, died in his home there February 7 after an illness of three years. He had been hospitalized several times during that period but had continued a part-time practice.

Doctor Gable was born in Clinton county in 1885. He received his medical degree in 1909 from the Chicago College of Medicine and Surgery and established his practice in Monticello in 1910. He was both physician and surgeon, having been surgeon for the Monon and Pennsylvania railroads for many years. He was on the staffs of Memorial and St. Joseph's Hospitals, Logansport.

Doctor Gable served as secretary of the White County Medical Society from 1917 through 1945. He was a delegate to Indiana State Medical Association's House of Delegates in 1944. In addition to his medical affiliations, Doctor Gable was greatly interested in travel. He had traveled and studied abroad extensively. He was an active member of several lodge groups and the Methodist church.

**John W. Henry Ranke, M.D.**, 83, died February 12 in St. Joseph's Hospital, Fort Wayne, where he was a patient for a week. A native of Fort Wayne, Doctor Ranke was graduated in 1896 from Jefferson Medical College, Philadelphia. He then did graduate work at Willis Eye Hospital, Philadelphia; attended the Eye, Ear, Nose and Throat Clinics at Vienna and Berlin Universities and on his return to the United States took additional graduate work at Harvard University.

He established his practice in Fort Wayne in 1901 where he specialized in ophthalmology and otolaryngology. He had been in retirement for several years. Doctor Ranke was an honorary member of the Fort Wayne Medical Society, received his 50 year certificate from Indiana State Medical Association in 1951 and was an associate member of American Medical Association.

He was a former staff member of Lutheran Hospital, Fort Wayne, and was an active church and lodge member.

**Bernard J. Bolka, M.D.**, 61, South Bend physician and surgeon since 1923, died February 21 in Sebring, Florida, following a heart attack. He had gone to Florida earlier for his health.

Doctor Bolka was a 1916 graduate of the University of Illinois College of Medicine, Chicago. He entered military service in 1917 and after combat service during World War I was discharged as a major in the medical corps. He was licensed to practice in Illinois, Michigan and Indiana. He practiced in Chicago before going to South Bend for permanent residence. He had served many years as St. Joseph county physician and was county coroner from 1932 through 1936. He was formerly on St. Joseph's Hospital staff, South Bend; was on the visiting staff of St. Mary's Hospital, Chicago, and was a lecturer at Loyola University. He was a member of his county medical society, the St. Joseph Valley Medical Society, the state and national medical associations.

**Eugen Eisenlohr, M.D.**, 69, who came to Terre Haute in 1922 where he had been in practice since, died suddenly February 28 in his home near that city. Doctor Eisenlohr was a native of Germany where he received his medical degree in 1909 from the university at Freiburg, Baden. He served with the German army during World War I.

Doctor Eisenlohr was a member of Vigo County Medical Society, the Indiana State and American Medical Associations.

**Virgil T. Abel, M.D.**, Vallonia, who had practiced for 52 years in Jackson county, died

at Schneck Memorial Hospital, Seymour, February 25, following a week's illness.

Doctor Abel spent his life in southern Indiana except for the period when he attended the Medical College of Ohio at Cincinnati. He received his medical degree in 1901. He opened his office in Vallonia in 1902 and had practiced there continuously. He was 76 years old. In 1952 he was awarded his 50 year certificate from the Indiana State Medical Association.

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**Brandt E. Lemmon, M.D.**, Putnam county physician, died March 2 in the Veterans' Administration Hospital, Indianapolis, after a two weeks' illness. He was born in Corydon in 1883 and was a graduate of Kentucky School of Medicine, Louisville, where he received his degree in 1908. He had been in practice in Cloverdale, Fillmore, Coatesville, Spencer and Indianapolis. Doctor Lemmon was a veteran of World War I, and had church, lodge and military organization affiliations. He was a member of Putnam County Medical Society and the Indiana State Medical Association.

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**John L. Larway, M.D.**, 84, retired Indianapolis physician, died March 5 in St. Vincent's Hospital, after a brief illness.

Doctor Larway was a native of Logansport. He received his medical degree from the Eclectic Medical College at Cincinnati in 1898 and immediately established his practice in Indianapolis. He retired in 1952. For 40 years Doctor Larway served as medical advisor to the State Life Insurance Company. He was a former member of the Indianapolis Medical Society and a 50 year club member of the Indiana State Medical Association.

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**Edward M. Sweet, M.D.**, who practiced medicine in Martinsville for 64 years, died March 7

in the Johnson County Memorial Hospital, Franklin. He had been ill for five weeks.

Doctor Sweet, who was 89, was born on a farm near Martinsville. He was graduated from the Medical College of Ohio at Cincinnati in 1890, returning to Martinsville to establish his practice. His son, Dr. Austin Sweet, was in practice with him from 1925 until his death in 1951.

Doctor Sweet served as Seventh District Medical Society president in 1906 and was a senior member of the Indiana State Medical Association and the Morgan County Medical Society.

He helped build the National Sanitarium at Martinsville and was active in its management for many years; he had served as director of the First National Bank at Martinsville for a number of years and as a member of the Martinsville school board. He was a member of the Masonic order, and Sigma Chi fraternity.

Dr. Sweet was the father of Mrs. Walter L. Portteus, Franklin. Doctor Portteus is president-elect of Indiana State Medical Association.

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**Ernst L. Schaible, M.D.**, Gary physician for many years and former mayor of that city, died after a brief illness March 6 in Sarasota, Florida. He and Mrs. Schaible were near the end of their vacation when Doctor Schaible suffered a heart attack.

Born in New Jersey in 1879, Doctor Schaible received his medical degree from the University of Michigan in 1908 and established his practice in Gary the same year. From 1938 through 1942 he left his practice to serve as Republican mayor of Gary and during that period instituted many reforms. He resumed active practice after leaving the mayor's office. He retired in 1952.

Doctor Schaible served as a delegate to the Indiana State Medical Association convention in 1937, 1938, 1939 and 1949; was a member of the committee on auto insurance in 1925, the township trustees liaison committee in 1937 and the committee on public policy and legislation in 1937-38. He was a member of local, state and national medical organizations.

# NEWS NOTES — from State and Nation

## A. C. P. Announces Series of PG Courses During Spring

The American College of Physicians has announced a series of postgraduate courses arranged through the cooperation of the directors and the institutions where courses are held. Where facilities are available the courses are open to non-members who have adequate training.

First of the series was held March 15-19 at Louisiana State University School of Medicine, New Orleans; and the second, March 22-26 at Columbia-Presbyterian Medical Center, New York.

Course No. 3 on Clinical Electrocardiography is scheduled for April 19-24 at Wayne University College of Medicine Auditorium, Detroit.

Course No. 4 will be held April 26-30 at Northwestern University Medical School's Thorne Hall, Chicago. Subject of the course is Clinical Hematology. Dr. Robert J. Rohn,

director of hematology research, Department of Medicine, Indiana University Medical Center, is listed among the officers of instruction. He will present a paper on "Blood and Bone Marrow Findings in the Collagen Diseases" at the morning session April 30 and will participate in a clinical pathological conference that afternoon.

Course No. 5 on Internal Medicine will be held at the University of Pennsylvania School of Medicine May 10-14; Course No. 6 on Diseases Due to Allergic and Immune Mechanisms will be at the University of Pittsburgh School of Medicine May 17-21; Course No. 7 on Internal Medicine will be held at the University of California Medical School, San Francisco, June 14-18; and Course No. 8 on Isotopes in Clinical Medicine is scheduled for Ohio State University College of Medicine, Columbus, June 14-18.

Complete details may be obtained from E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia 4, Pennsylvania.

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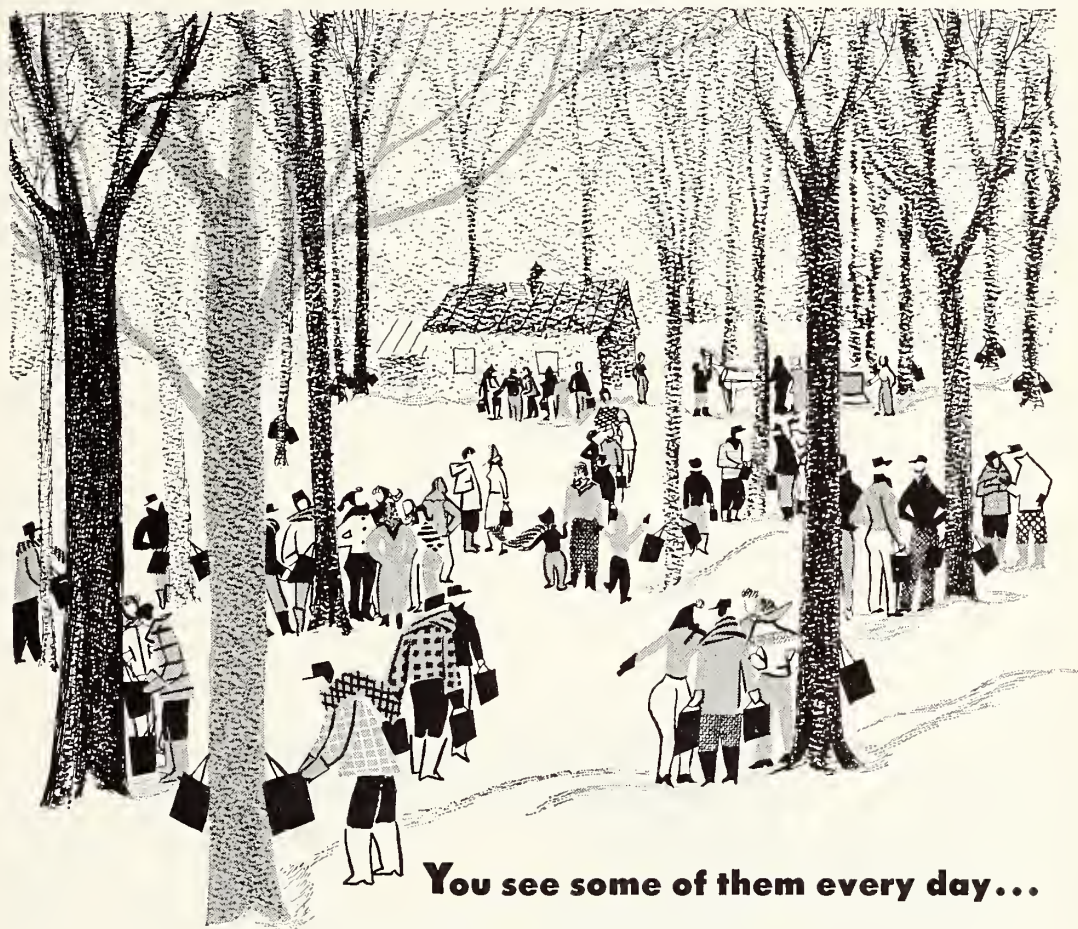
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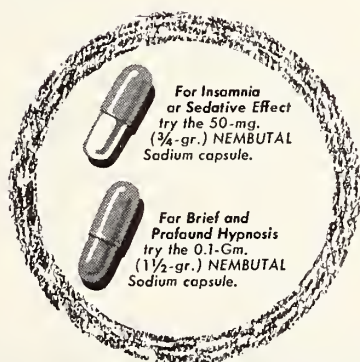




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### Open Essay Competition Has June 1 Deadline

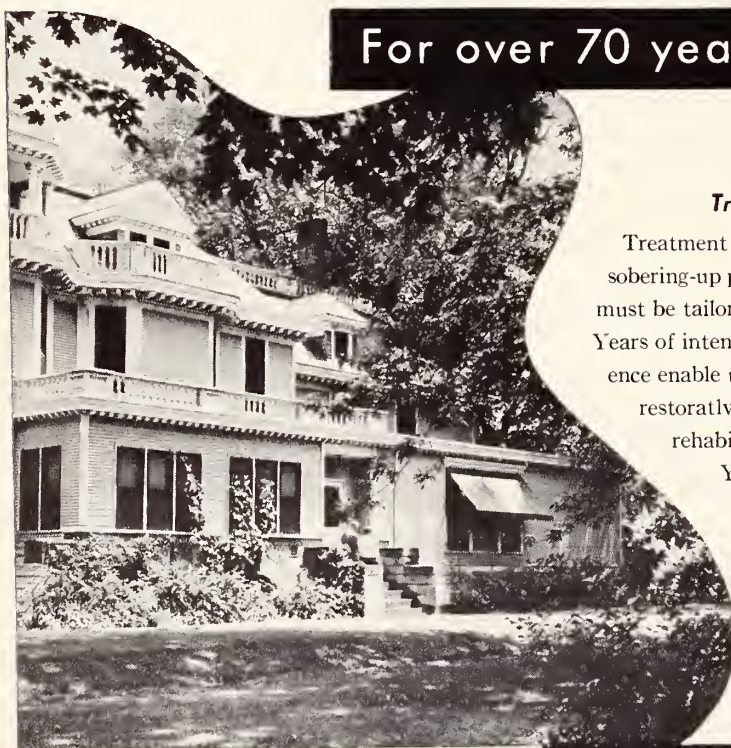
To stimulate interest in the field of physical medicine and rehabilitation the American Congress of Physical Medicine and Rehabilitation awards annually a prize for an essay relating to those topics. The contest, while open to anyone, is primarily directed to medical students, interns, residents and graduate students.

The following rules and regulations apply to the contest:

1. Any subject of interest or pertaining to the field of physical medicine and rehabilitation may be submitted.
2. Manuscripts **MUST BE** in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, not later than June 1, 1954.
3. Contributions will be accepted from medical students, internes, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.
4. The essay must not have been published previously.
5. The American Congress of Physical Medicine and Rehabilitation shall have the exclusive right to publish the winning essay in its official journal, the

### ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION.

6. Manuscripts must not exceed 5000 words (exclusive of headings, references, legends for cuts, tables, etc.), and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.
7. The winner shall receive a cash award of \$200, a gold medal properly engraved, a certificate of award and an invitation to present the contribution at the 32nd Annual Session of the American Congress of Physical Medicine and Rehabilitation at the Hotel Statler, Washington, D. C., September 6-11, 1954.
8. The winner shall be determined by the Annual Awards Committee composed of four members of the American Congress of Physical Medicine and Rehabilitation.
9. All manuscripts will be returned as soon as possible after the name of the winner is announced.
10. The American Congress of Physical Medicine and Rehabilitation reserves the right to make no award if, in the judgment of the Annual Awards Committee, no contribution is acceptable. The Congress may also award certificates of merit to contributors whose essays may be considered second and third best submitted. Announcement of the winner will be made after the annual meeting. Officers and members of the American Congress and the American Society of Physical Medicine and Rehabilitation are not eligible for this award.



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### Application Deadline Near On PHS Examinations

A competitive examination for appointment of medical officers to the Regular Corps of the United States Public Health Service will be held June 1, 2, and 3 at a number of points conveniently located for the candidates. Applications must be received no later than April 30.

Application forms and additional information may be obtained by writing to the Chief, Division of Personnel, Public Health Service, Department of Health, Education and Welfare, Washington 25, D. C.

**Dr. Marvin D. Utley**, a 1952 graduate of Indiana University School of Medicine, has begun a fellowship in medicine at The Johns Hopkins Hospital, Baltimore. He had previously served internships at the Seaside Memorial Hospital, Long Beach, California, and at the Deaconess Hospital, Evansville.

**Dr. Albert M. Ridlon**, who has been in Fort Scott, Kansas, for the last year and a half, is establishing an office for the general practice of medicine in South Whitley. He will occupy offices formerly used by Dr. Paul A. Garber.

Doctor Ridlon served four years during World War II, then returned to the University of Kansas where he received his degree in medicine in 1951. He served his internship at St. Mary's Hospital, Kansas City. He is married and has two small children.

**Dr. Charles O. Hamilton**, South Bend, was certified as a Fellow of the American College of Anesthesiologists December 14, 1953. **Dr. John F. Jackson**, Fort Wayne, received his certification January 6, 1954.

**Dr. Bertram Groesbeck, Jr.**, director of the Department of Health of the State of Indiana, presided at the 25th annual meeting of the Aero Medical Association which was held March 29 through 31 in Washington, D. C.

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### International College of Surgeons Plans PG Program

All members of the Indiana State Medical Association are cordially invited to a full day postgraduate meeting at the Indiana University Medical Center on Wednesday, May 26.

Nationally prominent physicians and surgeons will discuss pertinent problems of value to every type of physician.

Registration will start at 8 a.m. and the program will begin promptly at 9:30. The program at the university will be followed in the evening at 7 o'clock by a banquet at the Athenaeum where Dr. George W. Crane, columnist and author of the "Worry Clinic," will be the guest speaker. Wives and sweethearts are also invited, especially to the banquet meeting. The program is sponsored by the Indiana Section of the International College of Surgeons.

The Medical Library Association will hold its Fifty-third Annual meeting June 15-18 in Washington, D. C. The headquarters will be in the Hotel Statler, and the official host the Armed Forces Medical Library.

Dr. Ray Belding, Gary native and 1952 graduate of the Indiana University School of Medicine, has assumed the practice of Dr. W. F. Dunham who died recently at Kempton. Doctor Belding served with the army three years during World War II and was a prisoner of war for six months. On his return from service he completed his education. After receiving his medical degree he served a one year's internship at Good Samaritan

Hospital, Phoenix, Arizona, and an additional year as an associate in internal medicine at the Grunow Clinic.

A reception was held late in February to welcome Dr. and Mrs. Belding and their two small children to Kempton.

Salem will have a new doctor in July when Dr. Roy L. Fultz completes his internship at Indianapolis General Hospital. Doctor Fultz is a native of Salem. He entered the navy following his graduation from Salem High school and served for nearly three years. He received his degree from Indiana University School of Medicine in 1953. Doctor and Mrs. Fultz have purchased a home in Salem which will be used as a combined office and residence.

The Third Interim Congress of the Pan American Association of Ophthalmology will be held June 17 to 21 in Sao Paulo, Brazil. The meeting is one of many official events in the celebration of the quadricentennial of the host city. The scientific program includes papers by several physicians of the United States. Presentations will be in English, Spanish or Portuguese with simultaneous translations in the other two languages.

The 22nd annual national convention of the American Society of Medical Technologists will be held at Miami Beach, Florida, June 13-17. Information concerning the convention may be obtained from Mrs. Maxine T. Ace or Mrs. Anna L. Rundell, Jackson Memorial Hospital, Miami, Florida.

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M. C. PITKIN, M.D., *Medical Director*

J. W. GIBBS, M.D., *Associate*

### Hoosiers Attend Epilepsy Conference in Columbus

A regional institute on the social aspects of epilepsy was held at Columbus, Ohio on March 19 and 20, under the auspices of the Ohio Society for Crippled Children. Among those from Indiana who participated in the program were: Alfred Sasser, Jr., superintendent, Muscatatuck State School; Dr. Diomedes Guertin, superintendent, Indiana Village for Epileptics, New Castle; Roy Patton, director, Cross Roads Rehabilitation Center, Indianapolis; Mrs. Elizabeth Robinson, executive secretary, Family and Children's Service, Fort Wayne; and M. O. Jeglum, executive director, Indiana Society for Crippled Children.

Dr. Ladislav D. Wojcik, a pediatrician, has been added to the staff of Davis Clinic, Marion, according to an announcement by Dr. Merrill S. Davis, director. Doctor Wojcik will limit her practice to children under 14. She is a graduate of Simmons College, Boston, served as a research technician at Peter

Bent Brigham Hospital, Boston, later taught for the Commonwealth Fund of the Massachusetts Department of Public Health. She was admitted to Harvard Medical School in 1945. After receiving her degree she interned at Peter Bent Brigham Hospital, served as a resident in medicine at Boston Children's Hospital and as a member of the staff in pediatrics at Mary Imogene Bassett Hospital, Cooperstown, New York. During 1950-51 Doctor Wojcik participated in research at the Blood Fractionation Laboratory at the Harvard University Department of Physical Chemistry. She came to Marion from the Children's Medical Center in Boston where she was a staff member.

Dr. F. C. Waltz, native of Hagerstown and 1950 graduate of Indiana University School of Medicine, has opened an office for the practice of general medicine and surgery at 417 North Main Street, Bicknell. Doctor Waltz entered the navy on completion of his schooling and has served the last four years. He came to Bicknell from Lakeland, Florida with Mrs. Waltz and their three children.



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T. J. Smith, M.D., Associate



# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### THE EXECUTIVE COMMITTEE

February 21, 1954

Roll call showed the following present: James W. Denny, M. D., chairman; E. H. Clauser, M. D.; Wm. Harry Howard, M.D.; Walter L. Portteus, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; J. A. Waggener, executive secretary; Robert J. Amick, field secretary.

Guest: J. William Wright, Sr., M.D.

### Membership Report

Number of members February 20, 1954---3,041\*  
 Number of members February 20, 1953---2,767  
 Gain over last year ----- 274  
 Number of members December 31, 1953---3,819

\* Includes

104—in military service (gratis)  
 66—\$10.00 members (residents and interns)

218—senior members

55—members, dues remitted by Council

2—honorary members

AMA dues paid: 1952---3,569; 1953---3,624\*\*;  
 1954---2,350.

\*\* 420 members permanently exempted in 1952 included in above figure.

### Headquarters Office

(1) Mr. Amick reported on his activities during the past month.

Mr. Bush filed a written report of his activities. It was brought out by Mr. Bush that 61 tape recordings were currently on loan, with 30 requests yet to be filled by the office.

(2) The secretary discussed the problem of handling the recordings if the volume continued at the present pace, and the committee agreed that if the secretary was successful in getting the program for the Rural Health Committee financed with outside money that the money appropriated to the Rural Health Committee could be used for purchasing better equipment to facilitate handling the recording library. This was approved on motion of Drs. Clarke and Portteus.

Statements of receipts and expenditures and report on the budget for January for the Association and *THE JOURNAL* were accepted by consent.

### Legislative Matters

#### National

The secretary reported on the AMA Regional Legislative Conference in Chicago on February 6.

#### Local

Dr. J. William Wright reported on the meeting with the Indiana Association of Licensed Nursing Homes and sought permission of the committee to prepare a questionnaire to be mailed in the *News Flash* to all physicians in an effort to obtain information which would be helpful to the Association of Nursing Homes in setting up certain criteria for operation. This request was approved on motion of Drs. Clauser and Portteus.

### Annual Convention, Murat Temple, Indianapolis, October 25, 26 and 27, 1954

Exhibit floor plan was approved by consent.

*Scientific exhibit.* The invitation and application form for scientific exhibits were presented to the committee and by consent it was agreed to leave this to the judgment of the Scientific Exhibit Committee.

The secretary presented the contract of Add, Inc., as decorator for the 1954 meeting, and the secretary was authorized to sign the contract on behalf of the association, on motion of Drs. Clarke and Portteus.

### Annual Convention, French Lick, 1955

*Dates.* The secretary informed the committee that the dates of October 16 and 23 were available, and the committee stated either date would be satisfactory.

### Organization Matters

Statement for \$10.00 for dues in the Indiana State Conference on Social Work was approved by consent.

A letter from the Colorado State Medical Society was referred to the Committee on Traffic Safety upon motion of Drs. Howard and Clarke.

Upon motion of Drs. Clauser and Portteus, the committee approved the request of the editor of *THE JOURNAL* to nominate Dr. George E. Armstrong for the Dr. C. C. Criss Award.

Letter from the Indiana Hospital Association, addressed to the president inviting the medical association to participate in the conference on patient care was approved by the committee, and the following members were named to serve as representatives of the association:

J. William Wright, Sr., M.D.

H. R. Stimson, M.D.

Cleon A. Nafe, M.D.

Lawson J. Clark, M.D.

The secretary read a memorandum from the International Association of Machinists relative to



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their attempt to establish group practice clinics for the use of their members.

The Seventh Joint meeting of the Veterans Liaison Committee was reported on by the secretary, and a letter written to the American Legion magazine by Dr. W. W. Peet, chairman pro tem of the Liaison Committee, criticising the Legion for its terminology in reporting in the Legion magazine regarding the AMA's stand on the controversial non-service connected issue and the reply from the editor of the Legion publication were read to the committee for its information.

#### The Journal

The advertising series of the Wine Research Institute, forwarded by the State Journal Advertising Bureau, was rejected by consent.

#### New Business

Acknowledgment from Mrs. Joseph H. Weinstein, expressing thanks for the remembrance sent by the association at the death of Past President Joseph H. Weinstein, M.D., was read.

#### Future Meetings

There being no further business the committee adjourned to meet again at 11:00 a.m., on Sunday, April 4, 1954, in the I. U. Student Union Building.

## THE RETREAT

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# News from the County Societies

Members of **Cass County Medical Society** and their wives met in Memorial Hospital, Logansport, February 15 for a dinner meeting and to hear a tape recording of a seminar on "Nutrition". Twenty-eight were present, including Kenneth W. Bush, field secretary for Indiana State Medical Association.

At a business meeting following the program arrangements were made to man the Red Cross Blood Bank on March 23. The next meeting was to be held at 6:30 p.m. in St. Joseph's Hospital, Logansport, on April 15.

**Clay County Medical Society** members met February 16 in the Maurer Wood building, Brazil, at 7 o'clock for a regular meeting. Eleven members were present. A film on "Chronic Otitis Media" was shown and the desire expressed to use films more frequently for the society's programs.

The January 19 meeting of the group was held at 6:30 p.m. in Brazil Elks Club. Following dinner a representative of Blue Cross-Blue Shield discussed Mutual Medical coverage.

The March meeting was scheduled for the Elks Club on March 16.

A noon luncheon meeting of the **Decatur County Medical Society** was held February 16 in the Decatur County Hospital, Greensburg, with 9 members present. Following a short business meeting, Dr. D. D. Dickson presented a paper on "Rehabilitation of the Hemiplegic."

Fifteen members of **DeKalb County Medical Society** held a business meeting in Sacred Heart Hospital, Garrett, January 12 at 9 p.m. The March meeting was to be held in Souder's Hospital, Auburn.

Dinner with members of the Woman's Auxiliary preceded the February 11 meeting of the **Dubois County Medical Society** in the Huntingburg Country club. The 10 members who attended heard Robert J. Amick, I. S.

M. A. field secretary, speak on "The National Legislative Outlook for Organized Medicine" and later joined in a discussion with Dr. John Bretz as leader. Topics covered were the medical forums, gamma globulin, and contagious diseases.

"Rising Trends in Hospital Costs" were discussed by M. R. Schultz, Blue Cross-Blue Shield field consultant, before members of the **Elkhart County Medical Society** March 4 in the Hotel Elkhart.

Eighteen members of **Floyd County Medical Society** met February 12 at 5 p.m. in the New Albany Country Club. Speaker for the evening was Dr. Robert McClellan who presented a paper on "Gout". The March 12 meeting was scheduled for the same time and place.

A joint meeting of the hospital staff and the **Fulton County Medical Society** was held in Woodlawn Hospital, Rochester, March 5 when the 10 members present discussed a number of matters of interest to the group including the possibility of a train trip to San Francisco for the A.M.A. convention, the conference of county



The above picture was taken at a recent **Fulton County Medical Society** meeting. From left to right are E. V. Herendeen; Kenneth K. Kraning, secretary-treasurer; Lawrence E. Kelsey, president; John C. Glackman, and Charles L. Herrick.





Dr. John H. Williams, Shipshewanna; Quentin F. Stultz, representing Noble County Medical Society; and Lloyd R. Studebaker, LaGrange, were photographed at a recent meeting of LaGrange County Medical Society.

medical society officers, and a public relations program.

A business meeting was held by four members of **Fountain-Warren County Medical Society** in the office of Dr. G. J. Himebaugh, Veedersburg, on March 4. The next meeting was scheduled for April 1.

"X-Ray Diagnosis of Gastrointestinal Lesions" was discussed by Dr. C. L. Poston, Laurel, before members of **Hancock County Medical Society** at their January 25 meeting in the Hancock County Memorial Hospital at Greenfield. Committees for the year were appointed and dues collected at a business meeting which followed. The February 22 meeting also was held in the county hospital.

**Harrison-Crawford County Medical Society** met in the Corydon County Hospital February 4 with six members and two guests present and on March 4 five members of the society held a business meeting in Corydon.

Dr. Edwin Lawrence, Indianapolis, was the guest speaker at the February 18 meeting of the **Henry County Medical Society**. He presented a paper on "Bilateral Adrenalectomy in Advanced Carcinoma of the Breast". The meeting was held at 8:30 p.m. in the Henry County Hospital, New Castle, with 24 members in attendance. The March 18 meeting was also to be held in the New Castle hospital.

Dr. Albert Unger, allergist, Chicago, addressed members of the **Howard County Medical Society** March 2 in the Francis Hotel, Kokomo. He spoke on "Treatment of Bronchial Asthma". Twenty-four members and 6 guests attended the dinner meeting.

At a business meeting which followed the society was unanimously in favor of future health forums to be conducted for the general public in cooperation with the aid of the local newspaper.

The next meeting was scheduled for 6:30 p.m., April 6, in the Francis Hotel.



Howard County doctors and their guests are pictured at their March meeting in Kokomo. Left to right are Drs. Raymond Sorenson, president of Howard County Medical Society; C. Tony Dutchess, Galveston, representing Cass County Medical Society; Elton R. Clarke, chairman of the I.S.M.A. Council; William N. Hutto; and the speaker for the evening, Dr. Albert H. Unger, Northwestern University, Chicago. The group at the right includes Drs. Robert W. Phares, Herbert M. Rhorer, Dutchess, and Durward W. Paris.



The above snapshots were taken at a February 16 meeting of the Fort Wayne (Allen County) Medical Society. From left to right are Dr. R. Morton Bolman, Dr. Robert P. Lloyd, Dr. Maurice E. Gloeck, Counselor; and Dr. A. J. Roser, president-elect of the society, and Dr. Paul L. Stier, chairman of the Board of Trustees.

Fifteen members of **Huntington County Medical Society** met in the Moose Lodge, Huntington, March 2 for dinner and later heard a paper presented by Dr. Julian Kaufman, Fort Wayne, who discussed allergies. A number of committee appointments were made. The April 6 meeting was also to be held in the Moose Lodge.

**LaPorte County Medical Society** members heard Dr. H. Close Hesseltine, professor of obstetrics and gynecology at the University of Chicago and staff member of the Chicago Lying-In Hospital, at their February 18 meeting in the Willard Sea Food restaurant, Michigan City. His topic was "General Body Health of Patients with Luekorrhoeas."

Dr. John Richter, president, was in charge of the meeting. Dr. S. S. Philbrook was accepted as a new member and Drs. Robert M. Rudisill and C. M. Sennett were welcomed as transfer members from St. Joseph County Medical Society.

The March 18 meeting was scheduled for Peacock Fountain Inn at Rolling Prairie and the April meeting was to be held at Beatty Memorial Hospital, Westville.

A luncheon meeting of the **Lawrence County Medical Society** was held March 3 in the Dunn Memorial Hospital, Bedford. Sixteen members and two guests viewed a

film on "Varidase" shown through courtesy of Lederle Laboratories.

During a business meeting the society discussed a number of pertinent problems and continued their discussion of the possibility of presenting a public medical forum.

The next meeting was set for noon in Dunn Memorial Hospital on April 7.

## The Norbury Sanatorium

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Montgomery County Medical Society met February 18 at 8 p.m. in Culver Union Hospital, Crawfordsville. Twenty-two members saw a film on "Normal Kidney Function" released by Eli Lilly and Company.

The March 18 meeting was also scheduled for Culver Hospital with Dr. Theron G. Randolph, Chicago, as guest speaker.

Twelve members of Morgan County Medical Society, their wives and several guests

attended a dinner meeting of the society at Martinsville Mineral Springs Sanitarium, Martinsville, February 21.

A business meeting was held at which Dr. William C. Stafford, Plainfield, represented Hendricks County Medical Society and discussed possible consolidation of the Hendricks and Morgan County Societies. Plans were made to hold several joint meetings on a trial basis.

A wire recording on "Treatment of Coronary Diseases" by W. D. Stroud, M.D., Philadelphia, was presented and it was voted to secure another recording from I. S. M. A. headquarters for the March 28 meeting which will also be held in Martinsville.

Dr. John B. Hamsher, Terre Haute, was the guest speaker at the Parke-Vermillion County Medical Society February 17 in the Vermillion County Hospital at Clinton. He spoke on "Diseases of the Scrotal Contents". Eleven members were present for the dinner meeting. The next meeting was scheduled for March 17 in the same place.

Putnam County Medical Society members met in the DePauw Union building, Greencastle, February 12, for a dinner meeting. Dr. G. W. Gustafson, Indianapolis, was the guest speaker. His topic was "Prolonged Labor". Twelve members were present.

Dr. Walter Seegers, research physician at Wayne University, Detroit, presented a paper on the "Latest Developments in Blood Clot-

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Groups attending the annual Medical-Civic dinner of the Vanderburgh County Medical Society February 18 are shown on this page. The event was held in Hotel McCurdy, Evansville.



Above are Dr. W. O. Denzer, president of Vanderburgh County Medical Society; Frederick C. Othman, Washington columnist for Scripps-Howard newspapers, who was the speaker; and Dr. L. Edward Gaul, president-elect of the Vanderburgh County Society.

ting Mechanisms" before 39 members and 14 guests of the Tippecanoe County Medical Society on February 9. Dinner was served in Lincoln Lodge, near Lafayette.

Following Doctor Seegers' talk, members had a roundtable discussion, adjourned for a brief recess and then held a business meeting. A number of pending projects were reported; Dr. R. C. Bolin was accepted as a member of the society by transfer from Ramsey County Medical Society of Minnesota and Dr. H. B. McAdams resigned as secretary. Dr. R. B. Dubois was named secretary.



Forty members of Wayne-Union County Medical Society heard a talk on "Cerebral Palsy" by Dr. Carl Martz, Indianapolis, at a meeting February 11 in Reid Memorial Hospital, Richmond. Doctor Martz is an orthopedic surgeon. E. J. Kidney, president of the United Cerebral Palsy corporation of Wayne County, was a special guest at the dinner meeting.



Dr. E. L. Fitzsimmons, Evansville, retiring president of Vanderburgh County Medical Society is shown right, receiving a plaque from Dr. Denzer, 1954 president. Dr. Gaul is in the foreground.

Mead Johnson & Company, Evansville pharmaceutical manufacturers, were well represented at the Medical-Civic dinner by Larry Wells, public relations director; Ben K. Harned, executive director of research; and J. Arthur Hill, general sales director. The bottom group, right, shows Arthur P. Tiernan, executive secretary of the host society; James A. Waggener, executive secretary of I.S.M.A.; and Dr. Minor Miller, Evansville, First District Councilor.



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All articles must be typewritten, double-spaced, with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Only a limited number of illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication of THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 10th of the month preceding date of issue.

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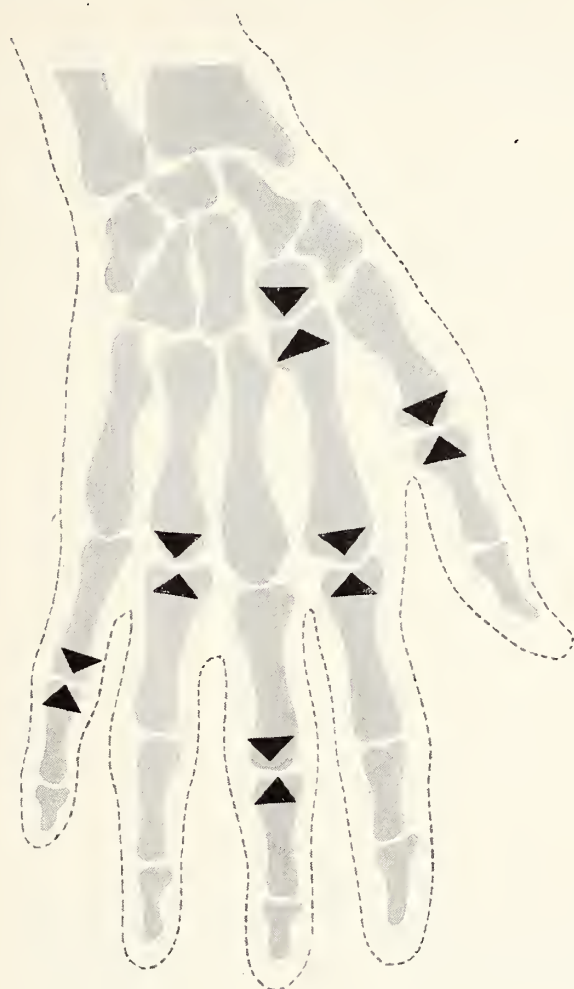


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## HOUSE COMMITTEE URGES 'FAIR TRIAL' FOR A NEW VA ADMISSION POLICY

A resolution adopted by the House Veterans Affairs Committee outlines the committee's attitude toward eligibility of veterans for medical care by Veterans Administration. These points are made:

1. The committee approves (a) the present unlimited hospitalization of service-connected cases, (b) the continued hospitalization of non-service neuropsychiatric and TB cases, and (c) the continued hospitalization of other non-service cases "where beds are available and the veteran does not have the ability to pay for private hospitalization."

2. The committee urges "all veterans' groups and all other parties interested in medical care for veterans" to defer final conclusion on eligibility until the new VA admission policy "has

been given a fair trial and a period of operation." Meantime, the committee recommends that no new legislation be considered on the subject of eligibility or admissions.

(In November, 1953, the VA put into effect a new 10-P10 form addendum on which the veteran applying for care of a non-service-connected condition would be asked to list his assets and liabilities. Under the law, however, VA cannot deny admission on the basis of information furnished on the form. The complete form was reprinted in SPECIAL REPORT NO. 13, November 13, 1953.)

In its resolution the committee notes that a subcommittee, under chairmanship of Bernard W. (Pat) Kearney (R., N.Y.), last year conducted hearings for a month on the subject of entitlement and eligibility. The committee emphasizes that the subcommittee took testimony from veterans' groups, medical societies (including AMA) and government officials. The committee's resolution is in effect an indorsement, for the time being, of the official policy of the Veterans Administration.

The American Medical Association policy on eligibility of veterans would limit the medical care of veterans to two groups: 1. Those with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated.

2. Within the limits of existing facilities, veterans with wartime service suffering from tuberculosis or psychiatric or neurological diseases of non-service origin who are unable to pay for hospitalization. VA should care for the latter group only until non-government facilities are adequate to assume the responsibility. Care of other non-service-connected cases would be the responsibility of the veteran himself or the community.



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## STATE'S FULLY ACCREDITED HOSPITALS LISTED BY JOINT COMMISSION

**T**HE JOINT COMMISSION on Accreditation of Hospitals recently released its annual list of fully and provisionally accredited hospitals in the United States and Canada.

The Commission gave full accreditation to 2,920 hospitals and provisional accreditation to 498, a total of 3,418. There are about 7,500 hospitals in the United States and Canada.

The list released is the first list published by the Joint Commission since it took over the actual hospital surveyal work from the American College of Surgeons January 1, 1953. The Commission is supported by the American College of Physicians, the American College of Surgeons, the American Hospital Association, the American Medical Association and the Canadian Medical Association. Headquarters are in Chicago.

In a statement accompanying the list, Dr.

Edwin L. Crosby, Director of the Commission at that time, said:

"The Joint Commission is a voluntary effort by our leading health organizations to improve the standards of hospital care through a system of self-evaluation.

"The Commission applies certain basic principles of organization and administration for efficient care of the patient, promotes high quality of medical and hospital care in all its aspects in order to give patients the greatest benefits that medical science has to offer, and promotes the maintenance of essential diagnostic and therapeutic services in the hospital through coordinated effort of the organized medical staff and the governing board of the hospital."

The accreditation program was started in 1919 by the College of Surgeons and was taken over by the Joint Commission as a cooperative effort



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last year. The 1953 list of accredited hospitals includes, as well as those actually surveyed by the Commission staff during the year, other hospitals which were not surveyed during 1953 but which were approved by the College of Surgeons as of December 31, 1952.

### Hospitals Make Requests

Dr. Crosby said that before a hospital is surveyed for accreditation the hospital must itself request such action. Hospitals under 25 beds are not eligible for accreditation. He pointed out that it had not been possible to visit all hospitals which requested accreditation during the year. There is no charge to the hospital for the accrediting service, the cost being borne by the participating organizations. The program costs about \$500,000 annually.

Before a hospital can be accredited, the Commission must determine that, among other things, it has a safe and adequate physical plant, with special concern as to fire hazards; that its governing board is properly organized and assumes final responsibility for all aspects of the hospital operation; that its medical staff is organized properly and through regular medical staff meetings reviews the clinical work in the hospital; that all tissue removed at operation is reviewed regularly to determine the adequacy and justification of the surgical work in the hospital; that adequate medical records are made promptly and preserved.

Full accreditation means that a hospital meets the required standards of the Commission. Provisional accreditation means that the hospital fell just short. Such hospitals are re-surveyed within one year to determine if they have corrected the deficiencies shown in the original survey.

Dr. Crosby said, "A certificate of accreditation given to a hospital proves that it has voluntarily met the standards of the Commission which are designed to insure the public of the best possible hospital care. It means that the hospital is a safe place, and that the medical staff itself reviews the work of its members to guarantee that the patients are getting good care."

The following hospitals in Indiana are listed as fully accredited:

#### ANDERSON

St. John's Hickey Memorial Hospital

#### BEECH GROVE

St. Francis Hospital

#### BLUFFTON

Clinic Hospital

#### COLUMBUS

Bartholomew County Hospital

#### CRAWFORDSVILLE

Montgomery County Culver Union Hospital

#### CROWN POINT

James O. Parramore Hospital

#### EAST CHICAGO

St. Catherine Hospital

#### ELKHART

Elkhart General Hospital

#### ELWOOD

Mercy Hospital

#### EVANSVILLE

Boehme Tuberculosis Hospital

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*\*English, A. R., et al.: Antibiotics  
Annual (1953-1954), New York, Medical  
Encyclopedia, Inc., 1953, p. 70.*



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# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## DOCTORS' HUGE POLIO FIGHT SERVICE

Perhaps the most monumental single public service project ever undertaken by the physicians of Allen County is the huge part they are going to play in an unprecedented nationwide polio vaccine test to be conducted this spring. The test will be held under the auspices of the National Foundation for Infantile Paralysis.

Some conception of the magnitude of the experiment may be gleaned from the fact that 3,500 second-grade school children of Allen County alone will take part in the vast experiment and will be inoculated with a remarkable new anti-poliomyelitis vaccine recently perfected by Dr. Jonas Salk at the University of Pittsburgh.

In addition, many thousands of other children in the first and third grades will not be given polio shots but will be included in the polio control test for critical comparison with the second-graders who do get the shots. Blood tests will be taken of the thousands of first and third grade pupils at intervals. One of the important advantages to these children will be the test curtain thrown about them, for through the blood tests presence of polio infection in the blood stream should be readily discovered.

Services of no less than 100 doctors, all of which will be donated, will be required to conduct the immense test here and make its results available for the mammoth nationwide experiment. If the test were just a "one shot" proposition, its magnitude would transcend any similar operation ever attempted here. However not one, but three shots must be administered at weekly intervals. This in addition to the many thousands of blood tests required.

The inoculations, of course, will only be administered to second-grade pupils whose parents give their approval.

The huge service, which the members of Fort Wayne Medical Society most commendably have volunteered to render entirely without cost, will of course not alone comprise the big job of administer-

ing a total of some 10,500 vaccine inoculations and many more thousands of blood tests. There will also be a vast amount of record and other clerical work to be done, all of which is also donated. The first shots are to be administered about April 15 and consummation of the test here will require at least five weeks.

A large amount of work is also represented in the preparation of instructions to the doctors themselves, to parochial and public school officials, and the forwarding of instructions and formal notifications of the forthcoming experiment to the many thousands of parents. All of the immense amount of detail will be worked out by the Medical Society, Dr. Walter E. Kruse, Fort Wayne City Health Commissioner and Dr. Paul Bailey, Allen County Health Commissioner. Much of the clerical spade work will be done under direction of Harry Lehman, executive secretary of the Fort Wayne Medical Society. . . .

Both Dr. Arthur R. Savage, President, and Dr. Arthur Roser, President-elect, of the Medical Society, pledge assurance of their personal co-operation and the hearty co-operation of every member of the Society.

How terribly the ruthless destroyer—polio—without warning, strikes down and kills or cripples its victims is so well known as not to admit of detailed description here.

Fort Wayne and Allen County have done themselves proud in combating polio in "The March of Dimes" and in the annual "Mothers March on Polio."

And now the community's doctors are exemplifying the same unselfish spirit in donating a vast amount of time and professional skill in marshaling their forces for this all-out mass experimental assault on this dread killer andcrippler, in a service that they alone are peculiarly qualified to render.

In this, we cannot commend their zeal to help suffering humanity, and their inspired dedication to their high calling, too highly.

—Fort Wayne News-Sentinel

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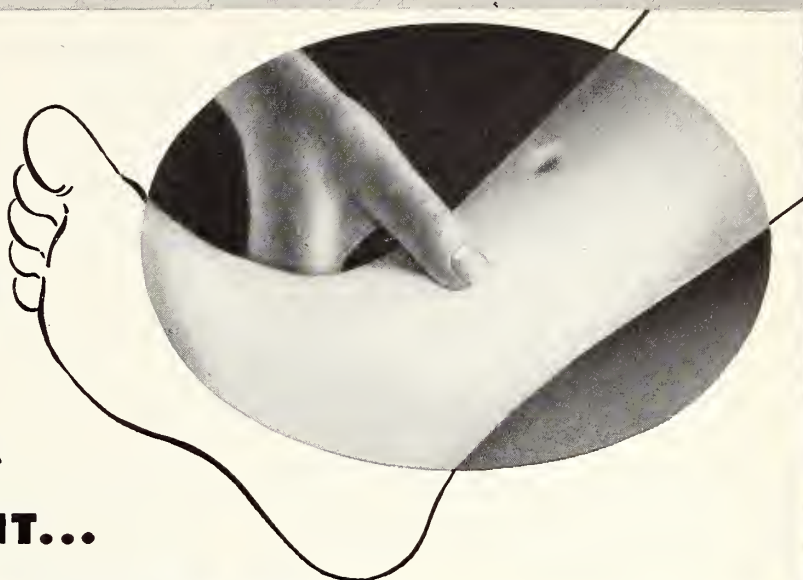
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1. Abramson, Julius, Bresnick, Elliott, and Sopienza, P. L.:  
New England Jour. Med.,  
243:44, July 13, 1950.

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# Medical Panorama—

A. W. Cavins, M. D.

Associate Editor

## TEXAS SURVEY OF DOCTOR SUPPLY

During the past year the Texas Medical Association has plowed several furrows in the field of facts concerning the "doctor shortage". Their Committee on Doctor Distribution "launched a survey of the profession itself. Questionnaires went to 6,500 doctors. Answers came from 6,000. The Committee established, to its satisfaction, that medicine's viewpoint held that help was needed in the ranks of the general practitioner, particularly in communities under 5,000, and most particularly in the northwest areas of Texas."

Accordingly, the committee decided to tackle "the problem of asking communities what they think." To avoid being swamped with replies on a statewide basis, one district was selected and letters were sent to "The Chamber of Commerce secretary, the Mayor, or the county judge as appropriate in each community with 800 population or more."

The results are given in the *Texas State Journal of Medicine* for February, 1954, from which the above "quotes" and the following excerpt are taken. The material below in quotation is from the letter sent out as noted above, the remainder is comment by the journal:

"One criticism most frequently heard is that there aren't enough doctors to go around. Actual facts show that the ratio of physicians to population in America is much higher than any other nation in the world.

"However, the medical profession of Texas recognizes that problems do exist, primarily in the area of

doctor distribution—not of doctor shortage. Our recent statewide survey has established this fact clearly.

"In this respect, we are making a sincere and continuous effort to extend medical service on the broadest possible base. Among many other things being done to place more doctors in rural areas, a special committee on doctor distribution has been created by the Texas Medical Association.

"The function of this committee is to work at the local level with qualified representatives of Texas communities where the facts show that such communities do not have enough doctors of medicine."

Then follows a paragraph of instructions for reporting any need for additional doctors, after which the letter continues:

"In the event that we do not hear from you, we shall know that you consider the number of doctors in your community as sufficient.

"Please understand that this is a sincere effort by the more than 6,500 members of the Texas Medical Association to establish the real facts as regards the distribution of medical care and, wherever possible, to do something about existing shortages discovered."

Committee members meeting in Austin in late January reviewed the findings of the survey. They revealed that not one community requested additional help. Conclusions reached by the committee were that either the distribution problem is not nearly so serious as medicine's critics would make it out to be, or the particular district under survey is happily far better off than others throughout the state.

In any event, the wisest course to the committee seemed to be to pursue the pilot survey through portions of three other districts until such time as it may be broached statewide, and materials for this purpose are now ready.

This seems to us to be real spade work on one of our most highly publicized medico-public-relations problems.

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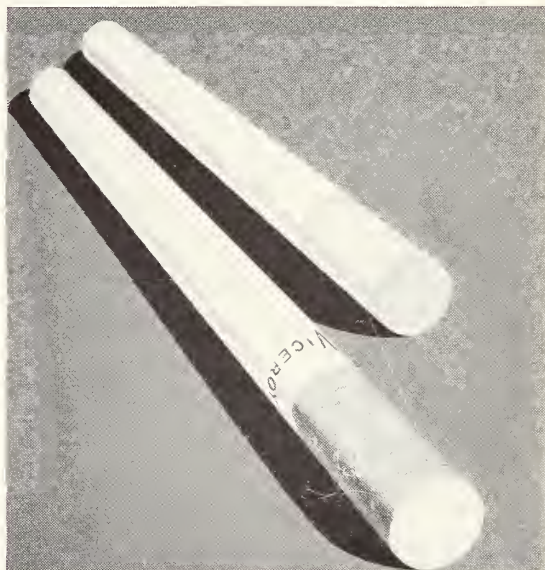


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## ADMINISTRATION'S REINSURANCE PLAN INTRODUCED IN CONGRESS

Bills to carry out the Eisenhower administration's plan for reinsuring prepaid health insurance plans were introduced in House (H.R. 8356) and Senate (S. 3114) on March 11. In explaining the program, the Department of Health, Education, and Welfare said:

"The program *would not* reinsure . . . a particular policyholder nor . . . a carrier as such. It *would* protect the carrier against bad experience in the aggregate under a particular reinsurance plan. Only abnormal losses and those in excess of anticipations would be reinsured . . . The carrier would share in paying these abnormal losses (U. S. share limited to 75%) . . . The program is designed to encourage carriers to experiment more broadly and rapidly . . . Success would depend entirely on voluntary action by (carriers)."

The program would be started with a federal appropriation of \$25 million. The objective is to make the fund self-sustaining within five years by scaling premiums to

match expenses, with the U. S. advance to be repaid. The federal obligation would not extend beyond the money in the reinsurance fund, or in separate funds if they are established.

*Responsibility for administration would rest with the Secretary of HEW, who would also fix rates of reinsurance and could cancel contracts for cause. State insurance authorities would be used to the maximum extent, including enforcement of compliance with regulations.*

*Plans Eligible:* Private insurance companies, voluntary nonprofit associations such as Blue Cross and Blue Shield, and other voluntary groups could participate if approved by the Secretary and if they complied with conditions and standards, including those noted below.

*Required of Plans:* The Secretary would establish terms, conditions and requirements for types of plans, taking into consideration these objectives: extension of coverage to persons not now protected, extension to new geographic areas and provision of benefits and services not

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## DIAGNOSIS, PREVENTION AND TREATMENT OF VENOUS THROMBO-EMBOLIC DISEASE\*

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IT IS WELL RECOGNIZED that venous thrombosis may be a serious event. Not only may it give rise to fatal or non-fatal pulmonary embolism, but if thrombosis involves the large veins of the lower extremity, a long chain of disabling complications of venous insufficiency of the limb may ensue. Venous thrombosis may occur as the result of local mechanical or chemical injury of veins, of a suppurative process involving the veins or as a sequel to pre-existing disease of the wall of the vein, such as varix.

Venous thrombosis also may occur and recur as a primary disorder without known cause. In most cases, venous thrombosis

which is seen in clinical practice, however, may be classed as "secondary" or "complicating." This type of venous thrombosis occurs during convalescence from surgical operations, childbirth and serious injuries, such as fractures, and during the course of infectious diseases, severe heart disease and visceral carcinoma. The exact reasons why venous thrombosis develops, sometimes but not always as a complication of these various conditions, are not known.

### No Distinction between Venous Thrombosis and Thrombophlebitis

It is generally agreed that complicating venous thrombo-embolic disease develops primarily as a thrombosis and almost always without demonstrable pre-existing endothelial disease in the involved vein. There is no evidence that bacterial or viral injury to the vein plays a part, even in those cases in which venous thrombo-embolic disease complicates

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diseases of bacterial or viral origin. Some confusion has arisen because an attempt has been made to divide venous thrombo-embolic disease into the categories of venous thrombosis and thrombophlebitis. The available evidence indicates that when embolization occurs, it develops soon after the formation of the thrombus—almost always within a few hours. If part or all of the thrombus remains in the vein, the thrombus soon becomes adherent to the wall of the vein and a variable degree of inflammatory reaction develops in the wall of the vein as a result.

Thus, while the condition starts as "venous thrombosis" (phlebothrombosis), unless complete embolization occurs, it soon develops into "thrombophlebitis." Since the reaction in the wall of the vein takes place rapidly, some phlebitis is present almost always by the time local symptoms or clinical signs are present which will permit the diagnosis of venous thrombosis to be made. For these reasons, I do not make a clinical distinction between venous thrombosis and thrombophlebitis in an extremity, since the two are merely stages of the same process. I do not believe such a distinction is of any value in determining therapy.

### Signs and Symptoms

The signs and symptoms which may lead to the diagnosis of thrombophlebitis (venous thrombosis) in an extremity vary, depending upon the vein which is affected. Thrombophlebitis of superficial veins usually is recognized easily by inspection and palpation, which reveal it as an elongated nodule or cord, often with some redness of the overlying skin in the course of one of the superficial veins.

It may be necessary to exclude certain other inflammatory nodules, such as those caused by erythema nodosum, erythema induratum and nodular vasculitis, which usually are more circular. When the condition is doubtful, the diagnosis may be established by biopsy. The diagnosis of thrombophlebitis of the long or short saphenous veins also may be made by inspection and palpation, since these veins also are relatively superficial.

The most difficult diagnosis, and one which often cannot be made with certainty is

thrombophlebitis of the deep veins of the calf. Some recent work by Felder has shown that in almost all individuals there are one or two large muscular veins in the soleus muscle, the so-called sural veins, which empty into the posterior tibial vein just below the popliteal space. In the syndrome of thrombophlebitis deep in the calf the lesion usually is in these veins, rather than in the posterior tibial veins.

Any patient who complains of pain in the calf muscles coming on relatively acutely, particularly if it develops during the second week after operation, childbirth, injury, or during the course of a severe infectious disease, or episode of congestive heart failure, should be suspected of having sural thrombophlebitis. There may be a slight degree of enlargement of the calf and a slight degree of prominence of the superficial veins, although these signs are not invariably present. In my experience, the so-called Homan's sign or pain produced by forcible dorsoflexion of the foot is not a reliable diagnostic criterion, since it is absent in many cases and may be present in other conditions, such as irritation of the sciatic nerve root. Venography is not a practical procedure, and cannot be recommended as of diagnostic value in thrombophlebitis of the deep veins of the calf, since films are difficult to interpret. When a strong suspicion of thrombophlebitis of the deep veins of the calf exists, even though the diagnosis cannot be made with certainty, it is best to treat the patient for that condition.

If the thrombus extends into the lower femoral vein, there is generally somewhat more evidence of venous insufficiency as indicated by enlargement and congestion of the leg and tenderness in the popliteal space and along the distal portion of the femoral vein in Hunter's canal.

The diagnosis of iliofemoral thrombophlebitis can be made with more certainty on clinical examination. As with the other types, the condition usually comes on acutely. There may be fever, but the temperature rarely exceeds 102° F. Chills do not occur. I wish to emphasize the diagnostic triad of (1) enlargement of the leg and thigh as compared with the companion extremity, (2) prominence of the superficial veins, with or without



slight diffuse cyanosis of the skin, and (3) tenderness in Scarpa's triangle. In my experience, evidence of arterial or arteriolar spasm is rare in iliofemoral thrombophlebitis, although it may occur. Almost always the arterial pulsations are normal, and there is no decrease in the temperature in the skin of the foot and leg. Two conditions should be distinguished from acute iliofemoral thrombophlebitis. The first is sudden arterial occlusion, characterized by more severe pain, pallor and coldness of the extremity, collapse of the superficial veins and absence of arterial pulsations below the point of occlusion and absence of enlargement of the limb. The second is acute diffuse lymphangitis, characterized by swelling, diffuse redness of the skin, chills, high temperature and no prominence of the superficial veins.

Thrombophlebitis in the upper extremity is considerably less common than thrombophlebitis in the lower extremity. In general, the same criteria for diagnosis obtain. Axillary subclavian thrombophlebitis produces a similar triad, namely, enlargement of the extremity, prominence of superficial veins and local tenderness in the axilla.

The diagnosis of pulmonary embolism may offer some difficulties. A small embolus producing pulmonary infarction as a rule is characterized by the sudden onset of pleural pain followed frequently but not always by hemoptysis. The physical findings are often less striking than the symptoms. There may be slight transient fever and tachycardia, and there may be dullness, suppression of breath sounds and râles in the affected region. A pleural rub often can be heard, but it is usually transient. Large pulmonary embolism, if not immediately fatal, generally is characterized by the sudden onset of pain in the midline of the chest, prostration, dyspnea, sometimes cyanosis, marked tachycardia and a decrease in blood pressure. When either of these clinical syndromes develops from the sixth to the fourteenth day after operation, childbirth or severe injury, or in any patient who has been confined to bed for an extended period, pulmonary embolism should be strongly suspected.

### Roentgenologic Aspects

Unfortunately, there are no characteristic roentgenologic signs which are pathognomonic of pulmonary embolism and, as with the findings on physical examination, the roentgenologic findings are often minimal as compared with the symptoms. In the presence of pulmonary infarction there may be elevation of the diaphragm on the affected side, enlargement of the hilar shadow and a pleural reaction in the region of the infarcted area. Occasionally, but not commonly, a rounded or wedge-shaped area of density is seen at the site of the infarct. Once in a while there are bands of increased density which do not conform to the distribution of normal bronchial markings. When large pulmonary embolism occurs, there may be some evidence of enlargement of the right side of the heart and pulmonary conus and bilateral prominence of hilar shadows.

### Electrocardiographic Aspects

The electrocardiogram is almost always unchanged after small pulmonary embolisms or infarctions. Even after a large pulmonary embolism an electrocardiogram which gives normal results does not exclude the diagnosis. In some instances, however, electrocardiographic findings indicative of acute cor pulmonale may be helpful in the differential diagnosis of a large pulmonary embolism as opposed to acute myocardial infarction. Characteristic changes are prominent S I, inverted T 3 but not T 2, inverted T in leads V-4 or V-3 and all V leads to the right of this point, and sometimes the characteristic tracing of right bundle-branch block. The above findings may occur singly or in combination, and usually disappear after a few days if the patient recovers.

### Distinction from Pneumonia

As distinguished from pneumonia, pulmonary embolism rarely produces a chill, causes less fever, much less evidence of consolidation in the lungs on physical and roentgenologic examination and a greater tendency toward bright-red blood in the sputum; also, recovery of the patient and disappearance of

the signs and symptoms frequently are more rapid than when pneumonia has occurred.

### Prevention

In considering measures for the prevention of venous thrombo-embolic disease, it should be remembered that this complication is relatively uncommon. For example, clinically diagnosable venous thrombosis occurs among less than 5 percent of patients who have undergone laparotomy, even when no specific measures are taken for prevention. For this reason, any routine measures must be carried out for a large number of patients in whom thrombosis would not have developed in order to prevent the complication in a few. For postoperative and postpartum patients, avoidance of trauma or localized pressure on the legs during and after operation or delivery is important. Administration of fluids into the veins of the legs should be avoided. Early ambulation, adequate hydration, active exercises of the legs and the use of elastic stockings or elastic bandages on the legs have been adopted routinely in many institutions.

All these procedures probably have contributed somewhat to a reduction in the incidence of venous thrombosis. In spite of such programs, however, the complication has not been eliminated. There are some limits to a program of early ambulation. When studies with adequate controls have been made, the best results in the prevention of postoperative venous thrombosis have been obtained with prophylactic anticoagulant therapy with the use of one of the coumarin compounds. There is a small but definite risk of potentially serious bleeding when such a program is used, and it seems doubtful that such a program is advisable for all patients who have undergone surgical operations or even all patients who have undergone laparotomy. Obviously, such a program is also contingent on the availability of accurate tests of prothrombin time.

It is possible, nonetheless, to place some patients in the category of increased risks in respect to the development of thrombosis. This certainly applies to a patient who has had either thrombophlebitis or pulmonary embolism at any time prior to the operation. Such patients should receive postoperative

anticoagulant therapy because the risk of recurrence of thrombosis is high. Patients who have undergone an operation for carcinoma are certainly increased risks, so far as the development of thrombosis is concerned, whether or not the carcinoma has been removed surgically. Patients who are anemic, who are obese, who are elderly and who have persistent infection after an operation also are somewhat increased risks in respect to thrombosis. If good facilities are available for the supervision of anticoagulant therapy for the prevention of thrombosis, such therapy is justifiable for them.

### Active Treatment

In the active treatment of acute thrombophlebitis and pulmonary embolism, early diagnosis is essential. All measures designed for the treatment of these conditions are successful in proportion to how soon they are instituted after the clinical onset of the disease. Patients who have undergone operations or childbirth, have sustained fractures or who have had severe infectious diseases or heart failure, should be examined frequently for evidence of venous thrombosis.

The local treatment of thrombophlebitis, in my experience, is best carried out by keeping the patient in bed and applying hot wet packs to the involved limb. If there is any evidence of venous congestion or swelling of the limb, the limb should be elevated to an angle of 30 degrees. It is not necessary to keep the patient absolutely quiet. The hot wet packs and the elevation, if indicated, are continued as long as the clinical signs persist. Local tenderness usually is the last manifestation to disappear. This period of treatment should not exceed three weeks.

I do not believe there is any justification for attempts to make the patient walk during the acute stage of thrombophlebitis; on the other hand, there is certainly no justification for keeping the patient in bed for long periods, even when the thrombophlebitis involves the iliofemoral vein. As soon as the tenderness has disappeared, the patient may be allowed out of bed, but it is essential that an adequate elastic support be put on the leg from the toes to the knee. Such bandaging can be accomplished by the use of one, two



or three 3 or 4-inch semielastic web bandages; when the condition is severe a solid rubber bandage is advisable. Such a bandage should be worn for the next two to six months, depending on whether or not orthostatic edema develops without it.

This procedure of putting an elastic bandage on the leg as soon as the patient gets out of bed is not sufficiently stressed. Yet, in my experience, it is one of the most effective measures for the prevention of subsequent chronic venous insufficiency of the limb with its potentially disabling complications. If the elastic bandage does not prevent edema, it is not effective, and the edema will soon become chronic in many instances.

### Emergency Treatment

The emergency treatment for severe pulmonary embolism is the use of oxygen, papaverine hydrochloride,  $\frac{1}{2}$  to 1 grain administered intravenously, and atropine sulfate, 1/100 grain given intravenously. The latter two drugs are employed for the purpose of relaxing pulmonary arterial spasm and bronchial spasm, and although their effectiveness is not always apparent, it is sometimes dramatic. If the pulmonary embolism is small, producing only pulmonary infarction without decrease of blood pressure or shock, then these procedures are not necessary. Immobilization of the chest by taping is not desirable.

### Antibiotic Therapy

There is no rational basis for the use of antibiotic agents in the treatment of venous thromboembolic disease itself. Obviously, if the patient has an infectious disease caused by an organism sensitive to a certain antibiotic, this antibiotic should be used and probably will have been used. The use of antibiotics to prevent secondary infection in pulmonary infarctions is of very doubtful value, since such infection is a rare complication of pulmonary infarction. Moreover, there is ample time for the use of antibiotics when and if such an infection should be manifested clinically.

### Anticoagulant Therapy

I believe that anticoagulant therapy should be used in all cases of acute thrombophlebitis

and pulmonary embolism unless there are specific contra-indications to the use of anticoagulants. The rationale of anticoagulant therapy is the prevention of extension of thrombosis and the prevention of thrombosis in other veins. In a patient who has acute thrombophlebitis the danger of pulmonary embolism is not detachment of the thrombus which is known to be present but it is the development of a new thrombus. The record of anticoagulant therapy, properly given, is excellent both in prevention of pulmonary embolism in patients who have thrombophlebitis and in the prevention of additional pulmonary embolism in patients who have had one incident and have survived. It has been thought that anticoagulants have no effect on the thrombus which is already formed; however, a recently reported study in England on the canalization and restoration of blood flow through arteries of animals in which experimental thrombosis had been induced indicates that a much more rapid and more complete recanalization develops when an anticoagulant is used than when it is not.

There is a growing clinical impression that the early and intensive use of anticoagulant therapy shortens the course of acute iliofemoral thrombophlebitis and reduces somewhat the tendency toward subsequent chronic venous insufficiency of the limb. There is still no substitute for heparin for immediate anticoagulant effect, and if attention is paid to individualization of dosage on the basis of the effect on the coagulation time of whole blood, heparin may be employed alone for periods of a few weeks. It has the disadvantage of requiring parenteral administration and that of considerable cost. The coumarin compounds have been widely used as anticoagulants. In addition to dicumarol, ethylbiscoumacetate (tromexan) and cyclocumarol have been used effectively.

Phenylindanedione, which is not a coumarin compound but has a similar action, has also been used considerably. Recently, warfarin-sodium derivative has been under investigation, since it can be given intravenously. Its speed of action is more rapid and somewhat more consistent than that of the other coumarin compounds and phenyl-



indanedione, but it is not rapid enough to replace heparin when an immediate anticoagulant effect is desired.

The choice of these drugs, which produce their anticoagulant effect by inhibiting prothrombin activity, should be left to the physician. It may depend somewhat on his experiences with them. Tromexan and phenylindanedione have a somewhat more rapid and more transient effect than has dicumarol. Cyclocumarol has a somewhat more prolonged and more consistent effect than dicumarol.

At the Mayo Clinic we still use dicumarol, for the most part, although we often give an additional priming dose of tromexan. In a few instances, when the condition is resistant, we use cyclocumarol. The details regarding individualization of dosage of the coumarin compounds and phenylindanedione have been well described in the literature, and will not be repeated here. It is worth while to point out, however, that an ideal therapeutic range of hypoprothrombinemia is indicated by a one-stage prothrombin time which is two to two and a half times the normal for the laboratory making the tests. Also, I should like to re-emphasize the often-repeated dictum that coumarin compounds and phenylindanedione should not be used unless accurate and comparable one-stage tests of prothrombin time are available.

The best program of anticoagulant therapy for a patient who has acute thrombophlebitis of the sural, femoral or iliofemoral veins or who has pulmonary embolism is to start simultaneously with both heparin and one of the coumarin compounds, to continue administration of the heparin until the prothrombin time is in the therapeutic range, and then to continue treatment with the coumarin compound. An early diagnosis of thrombo-embolic disease and the immediate initiation of anticoagulant therapy are highly desirable.

There is always a small risk of bleeding when anticoagulants are used. In the case of heparin, the anticoagulant effect may be stopped quickly, if necessary, with protamine sulfate. In the case of dicumarol and related compounds, the prothrombin time can be

brought to normal within 12 to 24 hours by the administration of vitamin K<sub>1</sub>, orally or parenterally, in doses of 250 to 500 mg.

The transfusion of blood may be necessary if there is much loss of blood. Minor bleeding, such as microscopic hematuria or slight epistaxis, is not necessarily an indication for discontinuance of treatment with anticoagulants, but indicates further caution and close observation of the patient. It is worthy of note that patients who are eating poorly and patients who have had surgical operations two or three days previously may be more sensitive to the coumarin compounds than others; therefore, the first doses for these patients should be somewhat reduced. Treatment with anticoagulants should be continued at least until the signs and symptoms of the acute thrombo-embolic episode have abated and until the patient has been ambulatory for several days. In some instances in which the risk of recurrence is considered great, or in which there have been several episodes prior to the initiation of anticoagulant therapy, it may be advisable to continue anticoagulant therapy for several months.

### Surgical Measures

There have been numerous reports of the treatment of venous thrombosis of the lower extremities by surgical ligation of one or more of the veins. The rationale of this procedure is to trap the thrombus in the extremity, and therefore to prevent pulmonary embolism. In the case of venous thrombosis in the veins of the calf, popliteal and lower femoral veins, the recommended procedure is ligation of the common superficial femoral vein distal to its juncture with the deep femoral vein in the thigh.

There have been reports of success in removing a part or all of the thrombus from the distal segment after ligation. It is obvious that this procedure does not prevent thrombosis proximal to the site of ligation or in the other leg. It is also obvious that it is useless in the case of iliofemoral thrombophlebitis. Even the most active proponents of the procedure have admitted that pulmonary embolism has occurred in up to 8 percent of patients who have had ligation of one or

both of the common superficial femoral veins. It appears from the statistical standpoint that this operation is definitely less effective than well-managed anticoagulant therapy for the prevention of pulmonary embolism. The operation does not seem to increase the tendency toward subsequent venous insufficiency of the limb. Ligation of the femoral vein proximal to the saphenofemoral juncture has not been employed to any extent because this operation appears to aggravate greatly the tendency toward subsequent venous insufficiency.

The only rational operation for the prevention of pulmonary embolism from venous thrombosis in the lower extremities is ligation of the inferior vena cava. This operation is of some magnitude, and is not without risk to life. Reports in the literature have varied as to the development of venous insufficiency after the operation, but most writers have admitted that considerable venous insufficiency has developed thereafter, particularly in the limb in which there has been previous venous thrombosis.

In recent years there has been a trend away from the use of ligation of veins, even by several of the original active proponents of this procedure, in favor of anticoagulant therapy, since the major purpose of both is the prevention of pulmonary embolism. It would seem that the only indication for venous ligation—and more particularly ligation of the vena cava—is for patients who have recurrent pulmonary embolism in which anticoagulant therapy cannot be used, or for the rare patient in whom adequate anticoagulant therapy has failed to prevent recurrent pulmonary embolism. Even in these cases the operation should be done only with due consideration of the risks involved.

### Anesthetic Procedures

Anesthetization of the lumbar sympathetic ganglia by procaine hydrochloride or a similar agent was advocated some years ago for the treatment of iliofemoral thrombophlebitis. The rationale of this procedure was to relieve arterial and arteriolar spasm and also venous spasm, on the assumption that the latter condition was also present and

a factor in the production of the congestion and edema. It has been stated that the pain associated with iliofemoral thrombophlebitis is rapidly relieved by lumbar sympathetic block. In my opinion, this procedure is based on very questionable evidence in respect to the disturbance of physiology associated with acute iliofemoral thrombophlebitis. My clinical experience with the procedure has been very disappointing. It is true that pain is frequently relieved but the procedure itself cannot be done without occasioning pain, and there are other simpler methods of relieving the pain of iliofemoral thrombophlebitis, a pain which is rarely severe anyway.

The mechanism of relief of pain by anesthetization in this particular condition may well lie in the effect of the injection on sensory nerves, rather than on the sympathetics alone. The procedure is relatively safe in the hands of experienced physicians and surgeons, but complications and even fatalities have been reported. There is definite risk of hemorrhage if anesthetization is done in patients receiving anticoagulants. In my experience, the procedure is useless so far as relief of the acute venous insufficiency, congestion and edema of the limb are concerned, and it does not shorten the clinical course of the diseases.

Rarely, a patient is encountered who has unquestionable arterial spasm secondary to acute iliofemoral thrombophlebitis, and for such a patient lumbar sympathetic block may be indicated if the spasm does not release within the first one or two hours after the onset. If lumbar sympathetic block is contemplated, anticoagulants should be withheld until it has been done. Except in these cases of unquestionable arterial spasm, I personally do not feel that there is any indication for lumbar sympathetic block for patients who have iliofemoral thrombophlebitis.

### Summary

In summary, I should like to repeat that the diagnosis of thrombophlebitis (venous thrombosis) in the lower extremities should be made early. Diagnosis usually is not difficult if the clinical symptoms and signs are remembered. Similarly, the diagnosis of

pulmonary embolism and infarction should not be difficult. Roentgenograms of the thorax and electrocardiograms may be of help in the diagnosis of pulmonary embolism, although neither can be relied upon to furnish positive diagnostic criteria. Anticoagulant therapy is indicated in almost all cases of thrombophlebitis and pulmonary embolism or the combination of both. Oxygen, papaverine and atropine may be of value in the

treatment of severe pulmonary embolism. Early institution of treatment, with elevation of the limb and the use of hot wet packs, ambulation of the patient as soon as the acute signs and symptoms have disappeared and the use of adequate supports on the leg as soon as ambulation is begun, are important although often neglected procedures in the prevention of subsequent chronic venous insufficiency.

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**An Abstract:**

**IMMEDIATE GASTRECTOMY IN ACUTE PERFORATED ULCER**

The authors report their experience with the use of gastrectomy in twelve of sixteen consecutive cases of acute perforation about the pylorus. The operation performed was sub-total gastrectomy using the Hofmeister modification of the Billroth II procedure. The authors believe that in the hands of a skilled surgeon the emergency gastrectomy need have little greater risk than a later elective procedure.

They found wound infection to be more frequent following this emergency surgery than after an elective operation. The authors admit that the procedure cannot be routine but that it should always be considered in these cases and employed if surgical judgment permits its use. They say that they would not use it for an elderly patient whose perforation is complicated by pyloric obstruction since these patients usually have a low gastric acidity.

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Taylor, Raymond A., M.D., Schulman, Jesse, M.D.: Immediate Gastrectomy in Acute Perforated Ulcer. *J.M. Soc. New Jersey* 88:93, Vol. 51, Mar. 1954.



# MANAGEMENT OF CHRONIC OCCLUSIVE DISEASE OF PERIPHERAL ARTERIES\*

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## PREVENTIVE TREATMENT

**I**F ONE DID NOTHING MORE than adequately instruct the patient with chronic occlusive disease of the peripheral arteries in the proper prophylactic care of his extremities, it is probable that a significant number of individuals now coming to amputation would otherwise live out their life span without loss of limb. Every reasonable precaution should be observed in attempting to prevent unnecessary trauma to ischemic limbs. Such extremities are unusually vulnerable to injury of any kind—thermal, chemical, or mechanical. An ischemic limb not subjected to stress of this type may survive indefinitely, but the same limb, for example, if soaked in hot water, may quickly sustain a burn, with subsequent non-healing and gangrene requiring amputation. It is well to provide each patient with an instruction sheet, on which are described in simple terms the nature of the disease and specific pitfalls to be avoided. Emphasis is placed on the avoidance of the use of heating pads, hot water bottles, ice packs, or ointments or poultices other than those of the mildest type on the limbs, avoidance of careless trimming of nails or callosities, wearing of ill-fitting shoes, prolonged wearing of new shoes, and standing in snow or on ice. When a warm solution for soaking the foot is required, a bath thermometer should be used to determine that the temperature of the solution does not exceed 95° F. If trichophytosis pedis is present, a fungicide which will not traumatize the skin beyond tolerance (e.g., 1:10,000 aqueous solution of potassium permanganate) should be utilized.

Possible measures to prevent progression of the fundamental arterial disease should be considered. Progression of the occlusive arterial disease caused by polycythemia vera may be arrested by prompt administration of anticoagulants, phlebotomy, and subsequent control of the polycythemia by radioactive phosphorus or by interval phlebotomies. Progression of occlusive disease due to embolus from a fibrillating atrium may be halted by therapy directed toward conversion of the cardiac arrhythmia. The course of thromboangiitis obliterans may be arrested by the complete and permanent abstinence from the use of tobacco. The adequate control of diabetes, the use of low fat, low cholesterol diets in cases associated with hyperlipemia, and anticoagulant therapy in cases of progressive thrombosis or in embolic occlusive disease are of value. Preliminary studies indicate that the oral ingestion of a stereoisomer of cholesterol (sitosterol) may prove to be of clinical value in lowering blood cholesterol and therefore possibly of value in halting the progression of arteriosclerosis obliterans.<sup>1</sup>

Since abrupt impairment of arterial circulation occurs at some time in approximately 10% of all patients with arteriosclerosis obliterans<sup>2</sup>, it is well to instruct patients to report promptly any sudden change in pain, degree of coldness, pallor or rubor of a limb, since anticoagulant therapy may prevent development of secondary thrombosis to a degree incompatible with survival of the extremity. Patients should be advised to return periodically for re-evaluation, since it may be possible thus to detect and correct incipient cardiac decompensation or early anemia, which, if allowed to progress, may critically

\* Presented at the 104th annual convention of the Indiana State Medical Association, October 21, 1953, French Lick, Indiana.

compromise the survival of an ischemic limb just as effectively as may exogenous trauma.

### DEFINITIVE TREATMENT

Definitive treatment may be considered conveniently under the headings of measures to produce vasodilatation, control of infection, promotion of healing, relief of pain, maintenance of general health, reconstructive and obliterative vascular surgical procedures, and amputations. The usefulness of each type of treatment must be assessed individually in each case.

#### 1. *Measures to produce vasodilatation or to increase collateral arterial circulation.*

There are numerous non-surgical methods of producing vasodilatation, but their effects are temporary. Whether, as a result of their frequent repetition, a more permanent increase in peripheral blood flow occurs is difficult to prove with finality but seems to be probable; however, even temporary effects are of value and, when coupled with other treatment measures, may be sufficient to allow healing of ischemic lesions. The vasodilatation may occur principally in the skin, although recent work suggests that muscle blood flow also may increase<sup>3</sup>. Increased blood flow in the skin, however, is probably of more importance generally speaking, since most ischemic lesions of the extremities leading to gangrene begin in the skin.

Simple maintenance of a warm environmental temperature is effective in producing vasodilatation of the extremities. This may be accomplished by placing a patient in a warm room, by enclosing the ischemic limbs in a warm (approximately 90° F.) bed cabinet<sup>4</sup>, by preventing local loss of heat by the application of insulating stockings<sup>5</sup>, or by short wave diathermy applied to the trunk<sup>4</sup>. Heating cabinets must be dependably controlled by a thermostat, in order to avoid burning ischemic tissue. At the other extreme, exposure of an ischemic limb to cool air or to continuous moist packs which have been allowed to cool is definitely deleterious, and the simple avoidance of such situations indirectly encourages a degree of vasodilatation. Similarly, abstinence from tobacco and relief of pain, by eliminating vasoconstriction, favor vasodilatation. Use of the Sanders oscillating bed may be attended with an

increase in the temperature of the skin and has proved to be of definite value in conjunction with other vasodilating procedures<sup>6</sup>. Active postural exercises as well as simple passive dependency of the limbs may promote increased peripheral blood flow<sup>7</sup>, but there is some question as to the benefit of such increased blood flow when active exercise is utilized, since the added demands of exercising muscles for oxygen may nullify the otherwise beneficial increase in blood flow<sup>8</sup>.

The use of systemic vasodilators remains one of the most controversial subjects in the field of vascular disease. Recent studies indicate that blood flow and/or skin temperature in ischemic extremities may be increased by parenteral administration of such agents as hexamethonium (C-6)<sup>9</sup>, Priscoline<sup>9, 10, 11</sup>, Dibenzylamine<sup>9</sup> (688-A), Regitine<sup>12</sup> (C-7337), and Pendiomide<sup>13</sup> (BA-9295), refuting the widely-held belief that systemic vasodilators always cause harmful hemometakinesia<sup>14</sup>. The effect of these agents, however, varies considerably from patient to patient. The parenteral route of administration is often impractical and very close supervision is necessary to avoid toxic side-effects. Clinical observations suggest that the oral use of some of these newer compounds may be beneficial<sup>9, 12</sup> but further controlled studies will be necessary before this can be determined with certainty.

Regional measures to increase vasodilatation usually consist of chemical or surgical interruption of sympathetic innervation. In addition to relaxing vascular tone, sweating is abolished so that heat loss from evaporation is essentially eliminated. Chemical sympathectomy with procaine, if followed by a definite improvement in the temperature of the skin, usually presages a beneficial effect from surgical resection, but the absence of such an increase in skin temperature should not discourage sympathectomy. On the other hand, a definite drop in temperature following block is felt to be a contra-indication to surgical sympathectomy<sup>15</sup>. The effects of chemical sympathectomy from such agents as 95% alcohol may last from 3 to 6 months or longer. The main advantage of this procedure appears to lie in the sparing of the patient from a surgical operation, but the frequency of incomplete denervation and so-

called "post-block neuralgia" would seem to argue strongly against its use. Recently, a technique of performing continuous paravertebral sympathetic nerve block with procaine has been described<sup>16</sup>, and further study of this technique appears to be indicated. The results of surgical lumbar sympathectomy have been increasingly favorable<sup>17-22</sup>. In the absence of deep gangrene proximal to the toes, intractable pain, marked atrophy, or severe systemic disease precluding consideration of any major surgical procedure, this operation should be given careful consideration, both as a prophylactic and as a therapeutic procedure. Careful study has indicated that, although there is a gradual return of vascular tonus over a period of months<sup>24, 25, 26</sup>, a long-term beneficial effect on collateral circulation may be produced by surgical sympathectomy.<sup>21, 27</sup> In addition to the benefit of the procedure in the preservation of an ischemic limb, it has been noted that patients, who, after sympathectomy, later must undergo amputation of the lower extremity on the same side, have a lower mortality, lower morbidity, and a higher incidence of primary healing.<sup>15</sup>

## 2. Treatment of infection.

Adequate control of diabetes should make the diabetic patient no more in need of antibiotics than the non-diabetic; however, in actual practice such control frequently is not attained, and it has been our practice to give antibiotics routinely in these cases. Infection frequently is an important factor in the non-healing of ischemic lesions in the diabetic, and the use of appropriate antibiotic therapy may spell the difference between the loss or survival of a limb. Although it is generally held that infection is of much less importance in non-diabetics, there are occasional cases in this group in which antibiotic therapy may play a decisive role. The rule of thumb that a limb is virtually doomed, once osteomyelitis develops secondary to an ischemic lesion, has probably been overemphasized. Deep infected ischemic ulcers extending into joint cavities and associated with extrusion of cartilage, may yet heal slowly with conservative treatment.

Various types of pyogenic organisms can

be recovered from the ulcerative lesions of occlusive arterial disease.<sup>4</sup> Penicillin parenterally has proved to be the most useful single antibiotic in these cases; however, it is always well to obtain a preliminary culture and antibiotic sensitivity determination on any such lesion, in the event that the patient is allergic to penicillin or that the organism is not susceptible to it. The local use of topical antibiotics such as Tyrothricin, Bacitracin, or a combination of Polymyxin-B and Bacitracin, as an adjunct to other therapy, is occasionally of benefit.

## 3. Promotion of healing.

Healing of open ischemic lesions is aided indirectly by all the measures mentioned above. The presence of an eschar or a gangrenous portion of tissue may impair drainage of purulent material and exert pressure on underlying granulations, thus hindering the healing process. Local atraumatic debridement of such necrotic tissue with sterile thumb forceps and scissors is therefore advisable. Frequently, this may be facilitated by preliminary local application for 30 to 60 minutes of lukewarm moist packs. Then, if the necrotic fragments still are so firmly attached that attempts at removal cause pain or bleeding, it is best to postpone the procedure and repeat it in a day or two. In the case of deep ulcerative lesions of the foot, soaking of the affected extremity for approximately 30 minutes three times daily in a tub containing physiologic saline solution or a dilute aqueous solution of tincture of green soap at a temperature of approximately 95° F. is more effective in mobilizing necrotic debris than are moist compresses. Debridement by the topical application of enzymatic substances, such as streptokinase and streptodornase, may be helpful at times, especially after a trial of methods above has shown the debris to be rather firmly attached. In the case of shallow indolent lesions, powdered red cells often prove to be a valuable adjunct in treatment<sup>28</sup>. The use of ACTH or cortisone or of parenterally administered trypsin has not been shown to be of value in the treatment of chronic occlusive arterial disease of the extremities.



#### 4. *Relief of pain.*

The pain of intermittent claudication frequently is responsible for the patient's decision to consult a physician. The most important treatment is that which is directed to improvement of the underlying ischemia. As for the pain, often simple reassurance that the pain itself does not portend immediate serious consequences and instruction in the reduction of physical activities to a degree commensurate with freedom from this pain are sufficient to manage the problem. At present, there is no uniformly reliable method of accomplishing specific relief of this pain. The parenteral administration of tissue extracts is still advocated by some and it is claimed that approximately 50% of patients derive benefit therefrom<sup>4</sup>. Recently, subcutaneous Achilles tenotomy has been performed with variable success<sup>29</sup>, but the trauma of this procedure, though relatively slight, introduce the risk of non-healing in ischemic tissues and in addition produces a definite functional deficit in the leg. Daily graded exercises in the form of walking at specified speeds has been offered recently by some as a helpful treatment<sup>30</sup>. Although from one-third to one-half the patients may observe some improvement in this symptom after sympathectomy, in a few claudication becomes more pronounced postoperatively<sup>15, 17, 20</sup>. The efficacy of heparin as treatment for claudication must be seriously questioned in view of the results of a recent well-controlled study<sup>31</sup>.

The pain of ischemic neuritis, pretrophic pain and the pain of gangrene at times may defy all ordinary therapeutic attempts for relief. Here again, treatment is directed toward reduction of ischemia of the limb as a whole, which, if accomplished, may in turn be associated with relief of pain. Salicylates, whiskey, sedatives, or narcotics may be used when necessary. The use of the Sanders bed often affords great relief of pain. Occasionally, one is confronted with a situation in which intractable pain of ischemic neuritis prompts the patient to hold the affected limb in a dependent position for protracted periods, with the result that marked orthostatic pedal edema develops, which in turn further increases ischemia and leads to a vicious cycle.

In these cases, it is sometimes possible to produce deep sedation by barbiturates for a period of 24 to 36 hours, during which time the limb is elevated sufficiently to rid it of edema and thus establish a favorable trend toward increase in peripheral blood flow. Constant nursing care is essential in such cases. Continuous caudal analgesia has been recommended by some for a similar purpose<sup>32</sup>. Neurectomy of peripheral nerves has been performed at times with relief<sup>4</sup>. Not infrequently, lumbar sympathectomy is followed by a rather dramatic disappearance of pain. Pain due to osteoporosis in an ischemic limb is managed by the use of the usual measures for occlusive arterial disease plus encouragement in increasing the use of the limb. Testosterone propionate has been used successfully by Hines in cases of this type<sup>33</sup>.

#### 5. *Maintenance of general health.*

Any general condition producing anoxia may contribute to the ischemia of limbs which are the site of occlusive arterial disease. This has been well emphasized in two recent reports<sup>23, 34</sup>. Cardiac decompensation and anemia are examples of such conditions. The importance of performing a complete general examination in every case cannot be over-emphasized, because only in this manner can such contributory conditions be recognized and corrected. The presence in the limb of edema from any cause may decrease local blood flow, and steps must be taken to eradicate it. Simple avoidance of dependency frequently will allow edema to disappear. Many patients have varying degrees of malnutrition and avitaminosis, and adequate dietary intake including the essential vitamins, especially vitamin C, should be provided.

#### 6. *Reconstructive and obliterative vascular surgery.*

Recently, it has been possible to resect occluded segments of arteries and replace the resected segment either with an autogenous venous graft or with an arterial homograft obtained from a graft bank. Such procedures are indicated only in carefully selected cases. A *sine qua non* of such an indication is the demonstration of a focal occlusion by arteriography, since the procedure obviously would

be of little value in widespread occlusive disease. It appears that such operations are most useful in segmental occlusions or aneurysms of the abdominal aorta or the femoral artery. Lumbar sympathectomy is also advocated in these conditions. Thrombendarterectomy has been performed for similar lesions<sup>35</sup>. Blake-more has reported good results in producing narrowing and obliteration of abdominal aortic aneurysms by electrocoagulation<sup>36</sup>. Recent studies indicate that expectant treatment of popliteal aneurysm is hazardous<sup>37, 38, 39</sup>. The treatment of choice for a popliteal aneurysm not completely occluded by thrombus appears to be lumbar sympathectomy followed immediately by surgical extirpation of the aneurysm.

#### 7. *Amputations. Choice of anesthetic agent. Postoperative care.*

Amputation, in the last analysis, is an admission of the failure of medical vascular treatment, and should be reserved for cases in which a thorough trial of conservative treatment has not yielded good results or in which the lack of any chance of saving the limb is obvious. In the case of gangrene involving only a part or the whole of one or more toes, demarcation and spontaneous separation of the gangrenous tissue may be allowed; digital amputation may be tried, if, after conservative treatment, the adjacent viable tissue appears sufficiently healthy. Lumbar sympathectomy, if not contraindicated for reasons mentioned above, and if performed immediately before amputation, may improve the chances of healing at the site of incision.

When gangrene extends far proximal to the digit, digital amputation usually proves to be inadequate to allow healing. Transmetatarsal amputation as advocated by McKittrick<sup>40</sup> appears to have a place in such situations; however, in individuals who subsequently must use the limb in the pursuit of a livelihood, there is frequently early breakdown at the operative site and a secondary amputation at a higher level is then required.

When the aforementioned measures have been tried without resultant healing or if

gangrene involves a large region of the foot or leg, amputation of the leg or thigh is indicated. If the gangrenous region is extensive and associated with signs of systemic toxicity, a preliminary period of one to three days, during which the non-salvageable portion of the leg is refrigerated, may halt further toxic absorption and allow considerable improvement in the patient's general status so that amputation may then be performed with less risk. The decision as to whether to perform a mid-leg or mid-thigh amputation may be difficult. There has been a widely-held belief that the absence both of the femoral and popliteal pulsations is a rather strong indication for the mid-thigh procedure, but there is an increasing trend toward the performance of mid-leg amputations in the absence of popliteal pulsations and even of femoral pulsations, provided that ischemia of the proximal limb is not extremely severe<sup>41, 42</sup>. The mortality rate with mid-leg amputations appears to be lower and the postoperative functional deficit is definitely less than with mid-thigh procedures; however, to achieve these results special surgical technique, as described by Silbert and Haimovici<sup>42</sup>, is essential.

Obviously, local anesthesia is contraindicated in any amputation on ischemic tissues, since the trauma occasioned by the injections only further imperils the chances of healing at the incision site. Spinal anesthesia is advantageous because of the attendant regional relaxation of the peripheral vasomotor tone, provided a significant drop in systemic blood pressure can be avoided. General inhalation anesthesia may be utilized, if spinal anesthesia is contraindicated.

Postoperatively, especially during the post-anesthetic period until the patient has regained consciousness, it is of great importance to make certain that no prolonged focal pressure is allowed either on the remaining portion of the ischemic limb or on its contralateral ischemic member. A pillow under the feet and a support to hold the bedclothes off the limbs are helpful in this regard. If a mid-leg amputation has been performed, a well-padded plaster half-shell splint, applied to the posterior aspect of the lower thigh and



the stump, is useful in preventing flexion contracture of the knee joint.

### SUMMARY

Much benefit may be derived from the use of preventive measures and careful and thoughtfully directed palliative treatment in chronic occlusive disease of the peripheral arteries. Recent advances in vascular surgical procedures offer for selected cases promising forms of treatment which, in a limited sense, could even be classed as curative.

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No drug having been thus far found in the treatment of tuberculosis which kills all tubercle bacilli, the objectives of drug treatment in this disease still fall short of the eradication of all infecting organisms.—**William B. Tucker, M.D., *Annals of Internal Med.*, Nov., 1953.**

# MYOCARDIAL INFARCTION IN RURAL PRACTICE

## 1. Thromboembolic Complications in Patients Receiving No Anticoagulant Therapy

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*Mentone\**

### INTRODUCTION

SINCE THE REPORT of the Committee for Evaluation of Anticoagulants in Myocardial Infarction<sup>1</sup>, there has been a constantly increasing mass of published evidence relative to the status of such therapy. Its value appears to lie not only in the reduction of thromboembolic complications, but also in a definitely lessened mortality percentage in patients so treated. This reduced mortality is, apparently largely due to the decreased incidence of thromboembolism, including a reduction in the cases sustaining a subsequent infarction during their acute course.

Solandt and Best<sup>2</sup> first reported their experimental work in this field in 1938. However, it was not until 1945 and 1946 that Wright<sup>3</sup>, Nichol and Page<sup>4</sup>, and Peters et al<sup>5</sup>, reported clinical confirmation of the experimental work. The work by the above-mentioned committee of the American Heart Association<sup>1</sup> represented a carefully controlled study by 16 participating hospitals, and the evidence drawn from this was so conclusive that there has been little contradictory literature. Large series of cases from single hospitals, such as the report from Detroit by Smith, Keyes, and Denham<sup>6</sup>, have supported the original conclusions.

Negating reports have come from Russek and his co-workers<sup>7, 8</sup>, Feldman and his group<sup>9</sup>, Goldstein and Wolff<sup>10</sup>, Duff and Shull<sup>11</sup>, and others. Such adverse reports are usually based on the potential danger of

hemorrhage in patients receiving dicumarol under inadequate laboratory control. That this is a very real difficulty is well recognized by all workers in the field. Prothrombin evaluations are difficult, and require careful regulation of all elements in the test. Such control is not always possible, even in the best laboratories, and there is no doubt that the advent of more simplified tests will be of great value in reducing the incidence of anticoagulant-induced hemorrhage.

Inasmuch as dicumarol is only one of a number of chemical compounds which will retard coagulation, there has been an increasing amount of literature regarding products which may be more effective and less dangerous. Tromexan<sup>12</sup> is one such substance which has been carefully evaluated, and there are many more. It can apparently be stated, however, that none of the substitute preparations have been totally effective in clinical work. Dicumarol, despite its disadvantages, is still the most practical oral anticoagulant, in the opinion of most authors.

While agreeing with the basic concept of anticoagulant therapy, Russek<sup>7, 8</sup> feels that there are many mild or moderate cases in whom the danger of thromboembolism is less than the potential danger of dicumarol-induced complications. He has therefore attempted to classify patients according to severity of illness, and reserve the anticoagulants for those who are most apt to have trouble due to thromboembolism. Wright<sup>13</sup> and others strongly disagree with this and feel that there is no sure method by which

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From the Urschel Clinic for Diseases of the Heart.

patients can be so classified early in their disease, when anticoagulant therapy should be instituted.

Feldman and his group<sup>9</sup> were able to demonstrate no benefit from anticoagulant therapy in a group of 189 patients treated in a large general hospital. This report is somewhat in contrast to most of those which have been made from such institutions where the average case is apt to be more seriously ill than those seen in practice.

### REASONS FOR THIS REPORT

To the physician practicing in a truly rural area, such as constitutes a large portion of the state of Indiana, this matter of anticoagulant therapy is becoming of increasing importance. If he does not use such therapy he faces two-fold pressure:

The family may have read or heard of these new drugs which "prevent blood-clots", and will quickly determine if their loved one is receiving this medication.

The greatest pressure on the conscientious physician is his own desire to practice the best possible medicine. One needs only to see a relatively mild coronary occlusion transformed into a case of permanently helpless hemiplegia to realize that embolism following myocardial infarction can be a tragic business, something to be avoided by any reasonable and safe means.

On the other hand, the rural physician finds himself beset by the problem of adequate laboratory control if he uses the anticoagulants. The majority of hospitals which serve such areas have a capacity of less than 50 beds and in almost all instances the technical work is done by an individual who attends to both the x-ray and laboratory duties. There are relatively few calls for prothrombin time tests, and even the most capable technician will have difficulty in guaranteeing his work under such circumstances.

In addition, many patients with myocardial infarction are still treated at home, and daily prothrombin-time tests are almost an impossibility in such circumstances.

There are certain questions in this situation which need to be answered. Do the figures of

Wright<sup>1, 13</sup> represent a true cross-section of experience with regard to thromboembolism and mortality, or are they "weighted" by the acuteness of the observers, or by the nature of the practice reported? In regard to this last point, did the fact that all these 1,031 patients were seen in large city hospitals mean therefore that they were more seriously ill than the average patient seen in private practice?

Because of questions such as these, it appeared wise to evaluate a group of patients encountered in a predominantly rural practice, including for this study only those who received no anticoagulant therapy at any time during their course. To my knowledge, no similar group has been reported. Harrison<sup>14</sup> has reported a series from a hospital in a rural area, but all of his group were hospitalized for treatment, and all patients treated since 1948 received anticoagulants.

### MATERIAL

The series to be herein presented is not a selected one, adapted to prove or disprove any theses. The sole basis for inclusion was a positive diagnosis of myocardial infarction, confirmed by typical electrocardiographic changes, increased sedimentation rate, elevated white count and other supplementary evidence. 100 cases were chosen in order to make statistical analysis more convenient, but these were consecutive cases, the only basis for discard being an inconclusive diagnosis or the use of anticoagulant therapy. Four patients who died very quickly were included because they had been previously studied and found to have definite coronary disease, although no electrocardiograms were obtained in the final illness.

Not all patients were followed by the author continuously from the first attack, as many were seen in consultation, or even after a period without correct diagnosis during which time they had been active<sup>15</sup>. They were all, however, followed subsequently in order to provide accurate observation.

Of the group, there were 80 males, and 20 females. This ratio, 4-1, agrees favorably with most reported series. The average age of the males was 59, with extremes of 35 to



80. The females varied between 31 and 76, the average age being 62. (Table I)

Table I. Age and Sex Incidence

Sex	Number of Patients	Age Limits	Average Age
Male -----	80	35 to 80	59
Female ----	20	31 to 76	62

It is not a part of our present discussion, and no statistical tables will be presented, but our incidence of diabetes and/or hypertension agreed satisfactorily with other published series. There is no doubt that either condition increases significantly the seriousness of myocardial infarction in any patient, and there is likewise no argument as to the increased incidence of these possible etiologic factors in female patients suffering infarction.

### MORTALITY

In Table II we have shown the mortality for the group as a whole, and have also listed the percentages according to sex. Because some series do not include cases which die quickly, before any therapy can be instituted, we present such figures in Table III for comparative purposes only.

Table II. Mortality

Sex	Number of Patients	Number of Deaths	Mortality Percentage
Entire Group ---	100	22	22%
Males -----	80	13	16.2%
Females -----	20	9	45%

Table III. Mortality, Excluding Patients who Died Prior to any Therapy

Sex	Number of Patients	Number of Deaths	Mortality Percentage
Entire Group ---	96	18	18.7%
Males -----	77	10	13.0%
Females -----	19	8	42.1%

In Table IV we have included comparative figures from a number of published series, both with and without anticoagulant therapy. It may be seen that our mortality of 22% did not differ widely from published observations, being slightly lower than others treated

without anticoagulants. It is worthy of note that all of our patients were seen in the past 6 years, and thus received most of the newer methods of conventional therapy, except dicumarol. It would appear that myocardial infarction is neither more nor less dangerous in the country than in the city. This, incidentally, is in contrast to an observation quoted by Harrison<sup>14</sup>, in which there was a marked variation in mortality between rural

Table IV. Comparative Mortality Figures from Reported Series

Author	Number of Cases	Mortality Percentage
Smith et al <sup>6</sup>		
Without anticoagulants ----	731	25.4%
With anticoagulants -----	189	14.2%
Feldman et al <sup>9</sup>		
Without anticoagulants ----	76	30.3%
With anticoagulants -----	76	30.3%
Harrison <sup>14</sup>		
Without anticoagulants ----	143	51.0%
With anticoagulants -----	73	18.0%
Wright <sup>13</sup>		
Without anticoagulants ----	442	23.4%
With anticoagulants -----	589	16.0%
Russek and Zohman <sup>7</sup>		
Without anticoagulants ----	1047	33.4%
Author's Series -----	100	22.0%

and urban patients, farmers having a much higher death rate.

### THROMBOEMBOLIC COMPLICATIONS

In Table V we have listed the incidence of thromboembolic complications in this group of patients, while in Table VI these figures have been compared with other published series. This particular aspect of the

Table V. Incidence of Thromboembolic Complications

Sex	Number of Patients	Thromboembolic complications	Number sustaining	Percentage
Entire group ----	100		8	8.0%*
Males -----	80		6	7.5%
Females -----	20		2	10.0%

\* 8.3% if the 4 patients who died suddenly are excluded.

subject has been the source of much contention, as there can be no doubt that in-

Table VI. Comparative Incidence of Thromboembolic Complications from Reported Series

<i>Author</i>	<i>Number of Thromboembolic Cases</i>	<i>Incidence of Complications</i>
Smith et al <sup>6</sup>		
Without anticoagulants ----	731	19.4%
With anticoagulants -----	189	7.9%
Feldman et al <sup>9</sup>		
Without anticoagulants ----	76	7.9%
With anticoagulants -----	76	5.3%
Harrison <sup>14</sup>		
Without anticoagulants ----	163	30.7%
With anticoagulants -----	73	10.0%
Wright <sup>13</sup>		
Without anticoagulants ----	442	26.0%
With anticoagulants -----	589	10.9%
Russek and Zohman <sup>7</sup>		
Without anticoagulants ----	1047	6.0%
Author's Series -----	100	8.0%

creased acuteness of observation contributes to the total reported incidence of such complications. In our practice, especially, with many patients treated at home or on an ambulatory basis, minor thromboembolic episodes could undoubtedly escape detection.

It can be seen in this compilation of published statistics that there is a wide range of reported incidence of these complications. Such divergent observations are difficult to explain, and there still must remain the possibility that there is a lack of true scientific detachment in observing and reporting this controversial subject. There is, of course, no doubt that the incidence of such complications will be higher in the seriously ill patients because of the more appropriate climate for thrombosis. There is also no doubt that the complications themselves may be more readily recognized in a teaching institution than in the small rural hospital or home, because of more constantly accessible medical care in the person of interns and residents.

### RELATIONSHIP TO MORTALITY

This is a much more important aspect of the problem, and sometimes seems to come down to an "egg and chicken" type of argument as follows: Mortality is much higher in patients with thromboembolism; mortality is

higher in seriously ill patients; but since thromboembolism is also more common in seriously ill patients, are they dying because of the complications, or because they are more seriously ill anyway? It is hard to be sure which comes first in this situation, as almost all published series agree on these facts but the authors disagree as to where to place the emphasis.

In our series, there were three cases in which thromboembolism appeared to contribute directly to death. In two of these, the site of the embolism was intracranial, and the third patient had multiple pulmonary episodes.

In addition, one hypertensive patient died months following amputation performed because of a popliteal embolus, but his death was due to a recurrent coronary attack.

The remaining four cases sustaining a thromboembolic complication recovered without sequelae. Two men, aged 58 and 70, had mild transient hemiplegia, developing on the ninth and tenth day of illness, respectively. A 66 year old man had a pulmonary embolus on the twentieth day, a 71 year old man a similar episode on the twenty-fifth day.

Because we do not have autopsy confirmation of the exact cause of death in most of our patients, it is entirely possible that some deaths not so listed have been thromboembolic in origin. To evaluate this possibility we carefully reviewed the charts of the 19 patients not considered to have died of such complications. Fifteen of these died within the first seven days, all but three on the fifth day or earlier. (It is generally agreed that thromboembolic complications are rare in the first week<sup>6</sup>, although they may occur in the first few days.) Of the remaining 4 cases, 2 died in decompensation and 2 in uremia plus decompensation. None of these 19 patients had apparent peripheral or cerebral embolization. That some of them may have had pulmonary emboli is possible although all were followed closely enough to render this unlikely as far as any major episodes are concerned.

Because it is controversial, we did not include spreading infarction as a thromboembolic complication, although it is so con-

sidered in some reports. We had two such patients, both recovering from the attacks.

### DISCUSSION

Several points of interest are apparent in this study. Myocardial infarction appears to be no more dangerous in rural practice than in urban medicine, but neither is it less dangerous. There may have been a time in past years when the rural patient did not seek medical attention as rapidly as his urban brother, as Harrison<sup>14</sup> suggests, but this certainly is not true now.

The mortality in this series, 22%, or 18.7% if we exclude those patients who died too quickly to have therapy of any kind, is somewhat better than any other reported series treated without anticoagulants. The mortality, in fact, does not compare unfavorably with the series reported by Smith<sup>6</sup>, Wright<sup>13</sup> and Harrison<sup>14</sup> where anticoagulants were used. This would appear to lend some credence to an assumption that the figures which appear in the literature from large general hospitals are somewhat weighted by the fact that many less seriously ill patients do not get to the hospital at all. This has been suggested by many authors, but to my knowledge this is the first statistical evaluation of such a series of cases.

It would appear that the usual published mortality figures for myocardial infarction are somewhat in excess of those experienced in practice. Likewise, if this series is at all representative, the incidence of thromboembolism is lower than we have been led to believe by Wright<sup>13</sup>, Smith<sup>6</sup>, and others. Our incidence of such complications compares much more closely with the reported results of Feldman<sup>9</sup> and Russek.<sup>7, 8</sup> Whether this is due to lack of acuteness on the part of some observers or to hyperacuteness on the part of others, does not appear to be significant. In any published series, the incidence of severe peripheral thromboembolism is relatively low, and the high figures reported contain a large number of patients with pulmonary embolism, which infrequently has a direct and single effect upon mortality.

One cannot, in conscience, deny the disastrous effects inherent in thromboembolism, particularly in a massive embolus to an ex-

tremity or to the brain. Therefore, it is my opinion that we must give deep consideration to the use of anticoagulants in the treatment of myocardial infarction, even in rural practice. However, in instances where proper laboratory control is not possible, it does not appear to me that the individual physician has to feel that he is mistreating his patient if he does not use these measures. There can be no doubt that the danger of hemorrhagic complications is greater in the patient receiving anticoagulants without adequate control than is the danger of thromboembolism in any given patient.

### SUMMARY AND CONCLUSIONS

1. One hundred consecutive patients suffering from myocardial infarction, encountered in a rural practice and treated without anticoagulants, are analyzed in this report.
2. Mortality for the group was 22%.
3. Eight patients sustained one or more thromboembolic complications, and in three the complication was apparently the cause of death.
4. In routine practice, it does not appear that thromboembolism is as frequent a complication of myocardial infarction as one would be led to believe from the literature. Anticoagulant therapy has been proven to be of real value in many published reports, but for the practitioner in a rural area the decision as to whether or not to use it must be based upon the adequacy of the laboratory control available to him.

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*An Abstract:*

### CARCINOMA OF THE RIGHT COLON

In contrast to carcinoma of the left colon which frequently produces early obstruction with distention, small stools and often blood and mucus, right colon carcinoma may produce few and non-specific symptoms. The experience of the present writers follows that of Rankin. Separating these patients into three groups, they present case reports of patients falling into each group. The largest group which Rankin reports as constituting 60% of cases is made up of patients with vague or dyspeptic complaints, sometimes colicky abdominal pain, at times alternating constipation and diarrhea, or at other times with a picture suggesting gallbladder disease. Occasionally localized pain will bring these patients to surgery with a diagnosis of appendicitis. There is always the hazard of considering these patients strictly neurotic. About 30% of patients with this lesion complain first of weakness and are found to have severe hypochromic anemia, the mechanism of which is not well understood. While their stools are usually not grossly bloody a high percentage will be positive for occult blood. The remaining 10% of patients may be asymptomatic with a tumor that is discovered accidentally. Diagnosis in these patients is not always easy and repetition of a barium enema should be done if any question remains. Diagnosis is important because the surgical results are quite good for cancer surgery.

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# ALKALOSIS AS A CAUSE OF PRERENAL AZOTEMIA

## A Review of the Literature with Five Case Reports\*

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### INTRODUCTION

THE FAILURE OF THE KIDNEYS to perform their normal functions of excretion and reabsorption will cause retention of non-protein nitrogenous substances and/or disturbances of electrolyte or water balance. This results not only from intrinsic disease of the kidneys, but also from disease processes elsewhere in the body. When nitrogen retention occurs in kidney failure due to disease processes elsewhere in the body it is referred to as prerenal azotemia.<sup>1</sup> This does not mean that the kidneys are entirely normal. Prerenal azotemia indicates that the primary disease is outside the kidneys. This disorder causes functional or even structural changes in the kidneys with renal impairment.<sup>1</sup> Prerenal azotemia is a common condition found in prolonged vomiting, as in intestinal obstruction and pernicious vomiting of pregnancy, severe prolonged diarrhea, acute infections, congestive heart failure, diabetic coma, Addisonian crisis, alkalosis, and shock.<sup>1, 2</sup> This paper, dealing with alkalosis as a cause of prerenal azotemia, reports five illustrative cases and is presented to call attention again to an often overlooked condition in medical and surgical practice.

The principal situations in which alkalosis may occur are (1) intensive use of alkalis in the treatment of peptic ulcer, (2) vomiting due to upper intestinal obstruction, and (3) removal of chloride by continuous gastric aspiration.

Alkalosis is now a relatively uncommon com-

plication in the treatment of peptic ulcer because sodium bicarbonate and the Sippy powders have been largely replaced by aluminum hydroxide preparations. However, the possibility of alkalosis in patients with peptic ulcer should be kept constantly in mind, particularly in those cases with pyloric obstruction and vomiting. Even continued gastric suction alone or with the administration of sodium lactate solutions may lead to alkalosis and renal insufficiency. It is dangerous for people to take antacids, such as soda bicarbonate, promiscuously.

In 1941 Kirsner and Palmer<sup>3</sup> using calcium carbonate in a series of experiments found that there was no direct correlation between the amount of calcium carbonate received and the development of alkalosis. In their experiments the acid-base balance remained within normal limits in some patients after the ingestion of as much as 48 grams daily for 42 days, while alkalosis occurred in other persons taking as little as 15 grams for four days. They also found that there was no significant variation in the total amount of base in patients with and without alkalosis. Patients may tolerate alkalis well for several months, and then suffer a change in the acid-base equilibrium of the blood to the point of alkalemia with its usual clinical picture.<sup>4</sup> In 1928 Stieglitz<sup>5</sup> wrote that the long continued clinical use of alkalis not infrequently led to evidence of clinical nephritis and alkalosis. Indeed Hardt and Rivers,<sup>6</sup> who in 1923 first recorded the symptoms of alkalosis accurately, found albumin, casts, and red blood corpuscles in the urine of patients who were undergoing

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intensive alkali therapy for peptic ulcer. Just as Kirsner and Palmer found that the amount of alkali necessary to cause alkalosis varies from one person to the other, so the quantity of ingested alkali necessary to cause renal insufficiency varies. An individual may consume relatively large quantities of alkali for a number of years before signs of renal impairment appear.<sup>7</sup>

The relationship between upper intestinal obstruction with vomiting and renal changes has been observed since Nazari in 1896 first described the deposition of calcium in the kidneys of patients dying as a result of this condition. Brown, Eusterman, et al (1923) described, in addition to calcification, granular and fatty degeneration of the renal tubular epithelium in cases of alkalosis induced by pyloric stenosis and vomiting, and they applied the term "toxic nephritis" to these pathologic changes.

Alkalosis and potassium deficiency occurring postoperatively has been described by various authors.<sup>8, 9</sup> The term "pancreatic asthenia" was given to this condition by Whipple in 1923. In 1949 Pearson and Eliel described such a syndrome of low serum potassium, metabolic alkalosis, hypochloremia, postoperative apathy, lethargy, anorexia, weakness, abdominal distention, and electrocardiographic changes typical of potassium deficit. Many of the patients had lost no gastrointestinal fluids. They presented evidence to show that the pathogenesis of this syndrome in postoperative patients was due to the alarm reaction producing hyper-function of the adrenal cortex, with loss of potassium and chloride (or retention of sodium) in the urine, associated with a low intake of potassium.

Besides the etiological factors already mentioned, there are several conditions in which alkali may not be tolerated well. It is dangerous to administer alkali to individuals with previously impaired renal function<sup>6, 10, 11</sup> or those with cirrhosis (Werelins 1922,<sup>10</sup>), emphysema,<sup>12</sup> or essential hypertension.<sup>13, 14</sup> Individuals so afflicted should be kept under close surveillance while on alkali therapy because they are more susceptible to the development of alkalosis than normal individuals.

The combination of alkalosis and renal insufficiency has been reported repeatedly and we must recognize that azotemia is a frequent complication of alkalosis. In 1926 Jordan<sup>4</sup> pointed out that "no evidence of renal insufficiency need

be present at the onset of symptoms or with the first rise of carbon dioxide content." Steele<sup>7</sup> said that the "... evidence of severe renal injury may occur before the development of obvious symptoms of alkalosis." Thus, there may be evidence of renal impairment or symptoms of alkalosis as the presenting problem. Not only is the definite nature of the renal pathology unknown but the mechanism by which this renal damage is brought about is still somewhat uncertain. Through the years there has been considerable disagreement among the various investigators as to the pathogenesis of the renal insufficiency. The usual pathologic changes in the kidneys are degenerative changes in the tubular epithelium with the distal convoluted tubules being the most severely<sup>1, 2, 15, 22, 23, 28</sup> damaged. These structural renal changes that have occurred in alkalosis have been ascribed to various causes: to absorption of toxins from intestinal obstruction (Haden and Orr, 1923 and Perez-Castro, 1937); to alkalemia *per se* (Stieglitz, 1924, 1928; Jordan, 1926; Addis, MacKay and MacKay, 1926, 1927)<sup>15</sup>; to decreased blood flow through the kidneys with decreased glomerular filtration as a result of dehydration;<sup>16</sup> to hemodilution with increased glomerular filtration without any increase in the effective plasma flow; to the activity of the renal tubules themselves; and to renal calcinosis.

## DISCUSSION OF CAUSATIVE THEORIES

In 1923 Brown, Eusterman, et al<sup>17</sup> presented data in which serious renal damage existed in many cases of duodenal and pyloric obstruction. One of the foremost hypotheses advanced at that time was the development of toxic substances in the proximal portion of the intestine and their systemic absorption. Whipple, et al (1914) believed that the toxic substance was either formed in the duodenal mucosa or was a product of bacterial autolysis, or both. The removal of the duodenal mucosa was believed to prevent the formation of these toxic substances. Hartwell, et al (1914) maintained that lack of water absorption or excessive loss of fluid, with the elaboration of a cellular poison from a gangrenous duodenal mucosa accounted for the toxemia and death in high intestinal obstruction. Dragstedt et al (1922) believed that bacterial action was essential for the production of these char-



acteristic toxic substances. Splitting of proteins produced a substance which caused the characteristic toxemia. In 1923 Gerard suggested that histamine might be the toxic agent causing renal damage. Werelius (1922) attempted to involve liver insufficiency as an etiologic factor in death following high intestinal obstruction.

Haden and Orr (1923) found that after experimental upper intestinal obstruction in dogs there was a fall in the plasma chlorides, a rise in the non-protein nitrogen and urea, and a rise in the carbon dioxide combining power of the plasma. They found that in many cases the toxic symptoms could be prevented by the administration of sodium chloride but not by the administration of sodium bicarbonate. It was their belief that the loss of chlorides was not accounted for in the vomitus. That the chlorides served as a protective factor against these toxic substances by neutralizing them or that the chlorides were utilized by the cells of the body as a means of defense against the toxic substance was suggested.

In 1920 MacCullum *et al* showed that the symptoms following obstruction of the pylorus could be prevented by furnishing a large supply of chlorides. However, they attributed the symptoms to alkalosis resulting from loss of chlorides through vomiting. They gave chlorides as a replacement for those lost and not as a protective factor.

Alkalosis, regardless of the cause, is invariably associated with a decrease in the serum chlorides. This relationship is explained by the total base concentration of the serum being maintained at a relatively constant level. The total base is combined for the most part with chloride and bicarbonate ions. Consequently, a change in the concentration of one of these anions causes a compensatory and inverse alteration in the concentration of the other. When the chloride anion becomes low the bicarbonate anion increases in quantity to replace the deficit chloride anion and alkalosis develops. In this manner, a normal electrolyte content and normal osmotic pressure of the blood are preserved. Hypochloremia is seen frequently in association with uremia, and has been thought to produce renal insufficiency. In spite of the association of alkalosis, hypochloremia, and renal insufficiency, extrarenal azotemia has been produced experimentally in the absence of hypochloremia. Likewise, hypo-

chloremia has been produced experimentally without azotemia (Clausen 1937 and Hiatt 1940). Normally the volume of extracellular fluids cannot be maintained without normal amounts of sodium chloride; consequently, the loss of these ions is invariably accompanied by a decrease in the extracellular fluid, or dehydration.<sup>3</sup> McCance found a reduction of 28 to 38 percent in the volume of body fluids in experimental human salt deficiency. He also observed a fall in the creatinine, sucrose, inulin, and urea clearance in experimental salt deficiency. The lowered renal efficiency in alkalosis then was attributed to dehydration (arising from salt depletion) with consequent reduction in the rate of glomerular filtration. The cause of renal insufficiency in dehydration arising from salt depletion was then a reduced rate of glomerular filtration and the alkalosis, or increased bicarbonate, was secondary. There was no vomiting and no ingested alkali.

Considerable work has been done to determine the cause of renal insufficiency in pernicious vomiting due to pregnancy and other causes. Dehydration, hypochloremia, and alkalosis occur and the best explanation seems to be that here again dehydration plays the predominant role by increasing the viscosity of the blood, and by decreasing the blood flow through the kidneys with subsequent impairment of renal function.

19, 20, 21, 22, 1, 23

Dehydration alone, however, cannot account for the azotemia observed in many of the cases of alkalosis. Polyuria has been mentioned frequently in published reports of alkali alkalosis and this is one factor that is incompatible with dehydration as being the only cause of the renal lesions in alkalosis.<sup>24, 5</sup> In 1932 Cooke<sup>20</sup> stated that a diuresis of 2000-3000 cc was not uncommon. In 1945 an Army Malaria Research Unit<sup>25</sup> working on the cause of renal insufficiency following the administration of large doses of sodium bicarbonate found a hemodilution of about 10% and an increase in the inulin clearance, which probably represented an increased glomerular filtration rate. There was no change in the diodrast clearance (a measure of the blood flow to the renal tubules). There was then an increased glomerular filtration rate without any corresponding increase in the effective plasma flow, and this effected a progressive impairment of tubular function.

The hemodilution was explained by the fact that there was a considerable retention of sodium because the kidneys apparently were unable to excrete sodium at the rate required to balance the intake. This increased sodium led to retention of water and there was a considerable dilution of the blood and tissue fluids. The increased glomerular filtration following the alkali may be further explained by alterations in the renal haemodynamics, so that the blood flow favors the glomeruli at the expense of the tubules. The exact mechanism of this is unknown but several investigators have indicated the probability that such a redistribution might take place.<sup>26, 27, 24</sup>

This same army research unit emphasized the fact that the high oxygen consumption of the tubular epithelium renders it especially liable to damage from anoxia. (Fishberg, 1939 and Scarff and Keele, 1943) "When large amounts of alkali are being excreted, the oxygen consumption would be especially high in that part of the tubule actively engaged in the regulation of the reaction of the urine—i.e., in the distal convoluted tubules (Ellinger 1940). In a state of relative anoxia arising from the concurrence of excessive work and diminished tubular blood flow the damage would therefore be likely to appear first in this site. This would provide a possible explanation for the observation by McLetchie<sup>28</sup> that in the alkalosis accompanying gastric tetany the main damage is in the distal convoluted tubules."

Renal calcinosis has been considered as a cause of renal damage in alkalosis. Perhaps the strongest proponents of this are Lowenhaupt and Greenburg (1946) who described an internal hydronephrosis developing as a result of calcium deposition in the lumen of the renal tubules. The exact cause of the renal deposition of calcium in alkalosis is not known, but numerous papers reporting this finding at autopsy are in the literature. Calcium deposition in the kidneys is only a minor contributory factor in causing renal impairment.<sup>4, 29, 30, 16, 28, 31</sup>

*In summary*, the causes of renal insufficiency in alkalosis as obtained from the literature have been discussed. There need be no evidence of previous gross renal damage. This is in accord with the belief that the renal insufficiency is the result, not the cause, of the alkalosis. If the alkalosis is adequately treated the kidneys usually recover completely their normal function within several weeks after the alkalosis has subsided.

When alkalosis develops in conjunction with loss of fluid, the dehydration plays the dominant role in the renal insufficiency by decreasing the renal blood flow, thereby decreasing the glomerular filtration, and also by decreasing the blood flow to the renal tubules. This decrease in blood supply to the tubules plus the fact that the alkalosis causes increased work on the part of the cells of the distal convoluted tubules favors the occurrence of degenerative changes in the tubular epithelium. Alkalosis occurring without the loss of fluid causes hemodilution and an increase in glomerular filtration with consequent diminished tubular blood supply. Here again the diminished blood supply plus the increased oxygen consumption of the cells of the distal convoluted tubules results in damage to the cells of the tubular epithelium causing impairment of the renal regulation of acid-base equilibrium and the damaged tubular epithelium may act as a dead membrane causing normal excretory products to be passively reabsorbed.

## CASE PRESENTATIONS

### Case I

T.M. (See Table I)

A white male, age 46, was admitted on 12-12-49 with the chief complaint of vomiting every evening for one week. Pain of peptic ulcer first occurred in 1932. After several months the pain disappeared without treatment. The next attack of pain was in 1945 and x-rays showed a duodenal ulcer. Treatment with a diet caused relief of ulcer pain, until the summer of 1948 when there was a recurrence. He again followed a restricted diet until his present admission. About one week prior to this admission typical ulcer pain recurred. The "hunger pains" were only partially relieved by food, and vomiting usually relieved the pain. The patient vomited every evening for a week prior to admission. A complete physical examination was negative except for slight tenderness in the epigastric region. His blood pressure was 110/80; pulse 112. Four days after entry x-ray showed the deformity of a duodenal ulcer and a large diverticulum in the upper portion of the descending duodenum. At four hours there was about 50% gastric retention. Upon returning to the hospital following a Christmas furlough, Levine suction was started on 12-26-49. Three days later the patient began to hiccough and this continued at

Table I

		T.M.				Admitted 12-12-49
Hospital Day		19	20	22	23	27 32
Date		12-30	12-31	1-2-50	1-3	1-7 1-12
NPN		130 Mg%	130 Mg%	55 Mg%		46 Mg% 39 Mg%
CO <sub>2</sub> COMBINING POWER		42.8 mEq (96 Vol%)				
CHLORIDES			44 mEq (255 Mg%)		86.5 mEq (502 Mg%)	
CREATININE				1.9 Mg%		
URINE		Neutral		Neutral		Acid

intervals for six days. On 12-30-49 muscle cramps developed and he felt exhausted. The next day he became very confused mentally and restraints had to be used. Two days after the onset of hiccoughs the NPN was 130 mgm% and the carbon dioxide combining power was 96 volumes percent. The Levine suction was stopped and intravenous fluids were started. Within 48 hours the patient's confusion began to improve and he did well thereafter. On 1-10-50 a subtotal gastric resection with gastro-jejunostomy after the anterior Polya method was performed. The patient did well after surgery and was discharged on 1-27-50.

It will be noted that at the time the patient's carbon dioxide combining power was 96 volumes percent, the urine was neutral in reaction, the NPN was 130 mgm% and the serum chlorides were low. With the establishment of treatment the NPN and chlorides approached normal levels. This represents a case of renal insufficiency secondary to an alkalosis and fluid loss

resulting from vomiting, gastric aspirations, and antacids.

### Case II

W.P. (See Table II)

This white male, age 68, was admitted on 8-1-51 with the diagnosis of a bleeding duodenal ulcer. Twenty-seven years previously he had had a bleeding duodenal ulcer. Two weeks prior to entry he began to have intermittent episodes of vomiting and his vomitus was brown in color. Physical examination revealed a well developed, well nourished white male who did not appear acutely or chronically ill. Blood pressure was 106/70, pulse 60. There was tenderness in the lower part of the mid-abdomen on deep pressure. The next day urinalysis showed alkaline reaction, specific gravity of 1.016 and negative test for albumin. The centrifuged sediment contained 3-4 hyaline casts, 5-7 fine granular casts, occasional coarse granular casts, 3-4 pus cells, occasional red blood cell, 3-4 epithelial cells in each

Table II

		W.P.								Admitted 8-1-51
Hospital Day		2	8	22	27	29	31	35	38	45 49
Date		8-2	8-8	8-22	8-27	8-29	8-31	9-4	9-7	9-14 9-18
NPN					117 Mg%	74 Mg%	77 Mg%	80 Mg%	49 Mg%	68 Mg% 68 Mg%
CO <sub>2</sub> COMBINING POWER		27.2mEq (61 Vol%)	32.5mEq (73 Vol%)			32.1mEq (72 Vol%)				28.5mEq (64 Vol%)
K					4.6mEq (18.4Mg%)					
CREATININE						2.6 Mg%				
CHLORIDES						73mEq (425 Mg%)				
URINE REACTION		Alkaline			Acid			Acid		Acid



Table III

L.R.

Admitted 12-13-43

Hospital Day	3	6	8	10	15	17	18
DATE	12-15	12-18	12-20	12-22	12-27	12-29	12-30
PSP							
1 Hr.	4.0%	8.0%	16.0%	18.0%	27.0%	30.0%	30.0%
2 Hrs.	4.0%	8.0%	8.0%	11.0%	8.0%	14.0%	11.0%
TOTAL	8.0%	16.0%	24.0%	29.0%	35.0%	44.0%	41.0%

high power field. CO<sub>2</sub> combining power on the seventh day was 61 volumes percent.

The patient was taken to surgery on 8-9-51 and a subtotal gastric resection was performed for a stenosing duodenal ulcer. He did well in his immediate postoperative period except for occasional vomiting. The vomiting, however, became more severe and the patient became mentally confused and weak. Twelve days after operation the CO<sub>2</sub> combining power was 73 volumes percent. On the thirteenth postoperative day barium meal showed a large dilated cardiac end and after three hours there was no x-ray evidence of the meal in the small intestine. On the next day he was again taken to surgery and massive edematous adhesions about the site of anastomosis were released. He continued to vomit occasionally for 10 days. A draining fecal

fistula developed and this was healed when he was dismissed on 10-9-51.

This is a case of alkalosis and prerenal azotemia resulting from excessive vomiting. It is extremely important that this complication of an obstructive duodenal ulcer be kept in mind and corrected before surgery. In this instance, within a few days complete obstruction of the outlet of the stomach complicated the gastric resection. The patient was in alkalosis when the second operation was done. This may have been a factor in the prolonged convalescence.

## Case III

L.R. (See Tables III and IV)

This 40 year old white male was admitted on 12-13-43 because of swelling of the legs, puffiness of the eyelids, tiredness, restlessness, in-

Table IV

L.R.

Admitted 12-13-43

Hospital Day	2	3	5	6	7	8	9	11	12	15	2 Yrs.
Date	12-14	12-15	12-17	12-18	12-19	12-20	12-21	12-23	12-24	12-27	4-28-45
NPN	96.0 Mg%	112.0 Mg%	80.0 Mg%	70.5 Mg%	67.2 Mg%	68.0 Mg%	54.0 Mg%	52.0 Mg%	50.0 Mg%	34.0 Mg%	38.0 Mg%
CREATININE	9.4 Mg%	6.6 Mg%	5.55 Mg%	5.1 Mg%	4.2 Mg%	4.4 Mg%	3.0 Mg%	2.65 Mg%	2.3 Mg%	1.9 Mg%	1.5 Mg%
URIC ACID		4.0 Mg%		3.1 Mg%							
CHOLESTEROL			223 Mg%								
TOTAL PROTEIN		6.9 Gm.	7.05 Gm.								
ALBUMIN		5.4 Gm.	4.8 Gm.								
GLOBULIN		1.5 Gm.	2.25 Gm.								
CO <sub>2</sub> COMBINING POWER		28.5mEq (64 Vol%)	24mEq (54 Vol%)	23mEq (52 Vol%)							
CHLORIDES								105mEq (610 mg%)			

sonnia, anorexia, dryness of the mouth, and slight blurring of vision. For about two months before admission he had been taking about 25 number one Sippy tablets per day for indigestion (probably nervous indigestion). His urine on admission was alkaline. The NPN was 112; the creatinine was 9.4 mgm.%.

Physical examination was essentially normal except for obesity, moderate tenderness in epigastrium, and moderate pitting edema of feet, ankles and legs, and slight edema of the eyelids. Blood pressure was 140/85. Funduscopic examination was negative. He was placed on a salt free diet, forced fluids, and potassium chloride. Response was satisfactory and he was dismissed with greatly improved renal function. His symptoms and abnormal physical findings had been relieved. Roentgen examination of the stomach and duodenum was negative.

The case presented a picture of alkalosis with impaired renal function resulting from excessive use of Sippy powders for indigestion. The return of the PSP excretion, NPN, and creatinine to normal levels on discontinuance of the antacid is well shown. The normal carbon dioxide combining power of 64 volumes percent was probably due to omission of the Sippy tablets prior to admission. Renal impairment exists for several weeks after alkalosis. Failure to recognize alkalosis as the cause of the azotemia and high creatinemia, etc. may lead to a fatal prognosis when the condition is really reversible as in this patient.

#### Case IV

B.P. (See Table V)

A 60 year old white male was admitted on 6-28-52 because of rectal bleeding of one to

two months duration. Rectal examination revealed a polypoid mass about 8-10 cm from the anus which proved to be carcinoma. Blood pressure was 145/80 on admission. The physical examination was otherwise negative. Two days later a combined abdominal-perineal resection was done. His postoperative course was marked by hiccoughing, vomiting, weakness, muscular hypotonia and irrationality. Because of the vomiting Levine suction was instituted and continued for several days. The patient did not do well and on 7-5-52 the serum potassium was 2.8 milliequivalents. On 7-7-52 the NPN was 68 mgm%. On 7-8-52 the chlorides (NaCl) were 67 mEq liter, sodium 144 mEq/liter and potassium 3.6 mEq liter. The CO<sub>2</sub> combining power on 7-9-52 was 87 volumes percent. With adequate fluid replacement the patient showed considerable improvement by 7-13-52, and he went on to recover from the alkalosis.

Protracted vomiting is a frequent postoperative complication. That alkalosis may develop is well demonstrated in this case of vomiting, alkalosis and renal insufficiency.

#### Case V

P.K. (See Table VI)

This 54 year old white male was admitted on 8-25-51 with the chief complaints of nausea and vomiting, abdominal distention, and periods of unconsciousness. Five years prior to admission the patient began to vomit almost daily. When the vomiting became very frequent the patient went to the hospital where he received infusions of saline. Improvement continued for 2-3 weeks and then the cycle would start over again. The

Table V		B.P.				Admitted 6-28-52
Hospital Day	1	8	10	11	12	14
Date	6-28	7-5	7-7	7-8	7-9	7-11
K		2.8mEq (11.2 mg%)		3.6mEq (14.4 mg%)		
NPN			68 mg%			
CHLORIDE				67mEq (388 mg%)		74mEq (429 mg%)
SODIUM				144mEq (331 mg%)		
CO <sub>2</sub> COMBINING POWER					38.8mEq (87 Vol%)	32.5mEq (83 Vol%)
URINE REACTION	Acid			Acid		

patient had been in other hospitals seven times in the last five years. With each of these episodes the patient had slight edema of his feet and ankles. With most of these he had jerking of his lower extremities starting with cramps in the calves of his legs. In March of 1951 he had a convulsion and was unconscious for six days. His last previous hospitalization had been in June 1951. Previous x-ray studies had revealed duodenal stricture. Two weeks before admission another cycle of nausea and vomiting began. One week later while being driven to the hospital in his home town he became unconscious and the next morning there was a generalized convulsion. He was treated with intravenous fluids and after some improvement he was transferred to St. Vincent's Hospital. On admission he was alert, but chronically ill. Blood pressure was 130/80. Other positive findings were: rales in both lung bases; bilateral pitting edema of the ankles and feet; and presacral area. At the end of six days the rales and edema had disappeared and the patient was progressing satisfactorily in anticipation of surgery. On the eighth day he suddenly decided to go home and against all advice he signed his own release. Six weeks later he died at home during a convulsion.

This case is perhaps the most educational one in our series. The man was hospitalized eight different times because of alkalosis, and on two of these occasions he had convulsions. On his last admission renal function was greatly impaired. He refused proper treatment and went

home only to die within six weeks presumably of marked electrolyte disturbance and renal failure. He might have been well today if he had accepted the proper treatment.

## SUMMARY

Commonly, alkalosis may result from the intensive or injudicious oral use of alkalis, such as sodium bicarbonate and calcium carbonate; from vomiting, as in high intestinal obstruction; and by removal of chloride by continuous gastric aspiration. Impairment of renal function with azotemia, creatinemia, hyponatremia, hypopotassemia, hypochloremia, lowered renal function tests, etc., often occurs. This renal impairment is reversible if the alkalosis is promptly treated with infusions of saline solution. Potassium chloride may be necessary. If it is not corrected in severe cases the condition is highly fatal.

The causative theories of the renal impairment in alkalosis, as obtained from the literature, are reviewed.

Five cases of renal impairment, or so-called prerenal azotemia, in alkalosis are presented. From our experience with this serious condition alertness to its occurrence should be more often emphasized in clinical medicine.

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Table VI

P.K.

Admitted 8-25-51

Date	8-26	8-27	8-28	8-29	8-31
NPN		140 Mg%			
CREATININE		7.3 Mg%			
CO <sub>2</sub> COMBINING POWER		(68 Vol%) 30.3 mEq			
TOTAL PROTEIN		4.3 Gm.	4.55 Gm.		
ALBUMIN		2.4 Gm.	3.02 Gm.		
GLOBULIN		1.9 Gm.	1.53 Gm.		
URINE REACTION	Alkaline			Alkaline	Neutral
PSP					
15 Minutes			2.5%		
30 Minutes			0.5%		
120 Minutes			3.5%		
TOTAL			6.5%		



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# The *Journal*

of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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## COMMISSION ON FINANCING OF HOSPITAL CARE

A COMMISSION, entitled as above, was organized in 1951, to study at length and report on problems in relation to hospital costs. Thirty-four individuals were appointed. They represented all the large agencies concerned with furnishing hospital care and many large groups interested in the purchase of hospital care.

The complete report will be published in three volumes early this summer. A preliminary report was released in January of this year. It contains "comprehensive recommendations for a broad program for strengthening and extending voluntary prepayment and for keeping the costs of the hospital services as low as possible consistent with good standards of care".

Gordon Gray, chairman, has stated that the recommendations were formulated "to point the way for effective voluntary action, with minimal participation by government,

to bring hospital care within financial reach of all people".

The preliminary report points out that measures are needed to reduce unnecessary use of hospital beds. This is the only way to keep the cost of voluntary insurance within the means of most of the people.

The Commission also reports on its statistical analysis of hospital costs, the results of which are amazing. When costs are adjusted for inflation and for the increased number of admissions, the cost per admission is found to have risen only 20% between 1935 and 1952.

Voluntary type of medical insurance is recommended as the best means of providing hospital care for the unemployed, the disabled and low income groups, and possibly public aid recipients. Emphasis is placed on maintaining the control of such programs

within states or smaller units. A provision for premium payments to be included in unemployment benefits and in old age benefits is suggested.

The proposal that voluntary prepayment costs be included in the unemployment compensation program, and the proposal that similar costs be included as a part of pension programs is not difficult to understand. The extension of this philosophy to the beneficiaries of the Federal Old Age and Survivors "Insurance" program is another thing.

This last mentioned item would seem to be the result of loose use of the word voluntary. The Commission is rightfully very proud of the voluntary system of medical insurance, and rightfully recommends it as the best and almost only system whereby citizens of ordinary means can meet their hospital bills. It is difficult to see how it is possible to apply the word voluntary to the Federal Old Age and Survivors "Insurance" scheme. It is compulsory, always will be compulsory and

wouldn't stand a chance of surviving if it were not compulsory.

The Commission, in spite of its tendency toward the socialistic side, must have avoided other socialistic pitfalls, as evidenced by a minority report. Two members, representing the CIO and AFL differed with the main report and charged that the recommendations placed unwarranted stress on the responsibilities of local communities, and did not place health insurance on a national base. They also objected to the voluntary approach because it charged members the same amount regardless of differences in earnings.

In a more constructive vein the Commission urged the formation of area study groups to standardize and improve benefit patterns, and to eliminate trivial special benefits which tend to obscure the real nature of a contract.

This report, based on a two-year, \$556,000 study by a well qualified and sincere group, contains data which will be invaluable in the future development of hospital prepayment insurance.

## ON PLUCKING A GOOSE

**U**NDER THE ABOVE CAPTION appears an editorial in the *Detroit Medical News* for December 21, 1953, which makes as clear a statement as we have seen of the facts concerning abuses and exploitation of voluntary health insurance, together with specific recommendations for control of the evil. The meat of the discussion is quoted here:

The extent of misuse of Blue Cross Insurance is revealed in a yet unpublished survey supervised by the Blue Cross Advisory Committee of the Michigan State Medical Society. Data tabulated from 12,102 completed charts studied in 25 Michigan hospitals (including 5 from Wayne County) were subjected to statistical analyses. When Blue Cross, commercial insurance companies, or the government paid the patient's bill, 33 percent of hospital usage was classified as improper compared to 14 percent when patients paid their own bills. According to the survey, almost 20 percent of the Blue Cross insurance dollar is spent on unnecessary hospitalization.

The doctor who controls admission, treatment, and discharge of the hospital patient is in a key position to control abuses and exploitation of the voluntary

health plans but he needs the help of the insurance companies, his patients, and the hospitals.

Blue Cross can help by more careful sales promotion. It can insist that its agents do not imply coverage not included in the policy. It would do well to give each subscriber a card welcoming him as a shareholder in this non-profit plan, but clearly stating that he cannot be admitted to a hospital for diagnosis only, that he cannot stay an extra day or two for the convenience of himself or his family, and that he cannot use his policy for nursing care in a hospital. If admissions of diagnostic workup continue, issuance of policies with deductible clauses similar to those designed for automobile collision insurance would simplify the physician's handling of unreasonable or oversold patients with Blue Cross coverage.

Hospitals can help by scheduling admissions earlier in the day, by eliminating delays due to bottlenecks in the ancillary services, delays in reporting tests, delays in notification of discharges, and by not winking at excessive amounts of expensive medicines released from the pharmacy at Blue Cross expense. Hospitals must not encourage patient overstays to keep the daily census high.

The patient can help by not demanding hospitaliza-



tion for diagnostic procedures or special treatments such as x-ray or physiotherapy, and by not insisting on staying extra days because it is inconvenient to go home. But the patient as a shareholder must be apprised of the purposes and fair usages of Blue Cross not only by the doctor but by Blue Cross itself.

The physician himself must avoid admitting well patients for diagnostic or therapeutic convenience, must avoid prolonged preoperative treatment, must avoid permitting overstays for the convenience of patient, doctor, or hospital, and must avoid overusage of medications, and unnecessary laboratory tests. The physician more than anyone else is in a position to keep down the costs of unnecessary hospitalization.

Let us not permit the Blue Cross goose to be plucked by exploitation—the Blue Cross goose whose golden eggs have saved not only our private hospitals from insolvency but many a patient with catastrophic illness as well. Let us remember that every fraudulent claim for voluntary health insurance represents a contribution to the war chest of Socialism.

Some of the above-mentioned suggestions

will be difficult or impossible of attainment on account of human nature being what it is, but many of them are practical and entirely possible to achieve. We refer particularly to more accuracy in insurance sales promotion, to the use of “deductible” type of policy (or rider) for diagnostic procedures, to elimination of certain delays in hospital services, and to more emphasis to the patient that he is a shareholder in a “mutual” project. The responsibility of the physician in discouraging abuses goes without saying, but he is often at a disadvantage in selling his proper point of view to the patient because the latter has not been properly educated as to what his insurance really is and how it has to operate in order to bring the greatest good to all who really need it.

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## LET'S HAVE SOME DISCUSSION

**F**REQUENTLY the most interesting part of a paper which is published in full after being read at a medical meeting is the discussion which follows it.

Discussants usually comment on a single element of the main presentation, and are able to enlarge on its interesting features more completely than the essayist who has been concerned with the entire subject.

Many of the scientific papers published in this journal are written especially for publication, have not been read at a medical meeting, and therefore do not have any discussion appended to them. In some instances a little

discussion in the way of amplification of a point, disagreement with a view, or presentation of another viewpoint would be apropos.

It is, of course, not practical to produce this discussion prior to publication, unless the paper has been read at a meeting.

However, THE JOURNAL staff wishes to invite all its readers to participate freely in discussion of the scientific papers through the medium of letters. These letters will be identified by the title of the original paper and will be published in a special section. We believe that this will increase the interest and teaching value of our scientific articles.

# The President's Page

FELLOW MEMBERS OF I.S.M.A.:

I JUST came back from New York where I attended the 1954 Conference of Blue Cross and Blue Shield Plans along with several of our Indiana Blue Shield Directors. Many of us have been enthusiastic about the movement for many years and have seen the plans grow up.

The National Association of Blue Shield Plans has 77 member plans. They have 30 million people enrolled at this time as compared to 1½ million in 1946.

The National Association of Blue Cross and Blue Shield Plans has embarked on a national advertising plan in Look, Life and Saturday Evening Post. This was undertaken to tell the Blue Shield and Blue Cross story and to help combat the growing group of imitators who are using various symbols that are closely associated with either the Blue Shield or Blue Cross. None of us have any crow to pick with a legitimate Insurance Company which is selling a good policy, in fact, if the Insurance Company as a whole would write a contract that was comparable to Blue Shield there would be little excuse for us to stay in the movement. As it is Indiana Blue Shield is paying out 85% of its premium dollar to the subscriber, 10% goes for selling and general overhead and 5% goes into reserve. Few of its competitors can match this payment to the subscriber at this time.

The American Medical Association has taken cognizance of the movement and has appointed Dr. Bauer to the Blue Shield Commission and will appoint two more over the next two years.

The Blue Shield Plans voted that they have given careful consideration to the Administration's reinsurance proposal and have come to the conclusion that it may be unnecessary with respect to Blue Shield plans for some of the following reasons:

An outstanding characteristic of Blue Shield Plans is that they have experimented and pioneered in a totally new concept of medical protection and have demonstrated their ability to stand on their own feet financially.

In but a few short years, Blue Shield Plans have made remarkable progress in both the extension of enrollment and the extension of benefits. Having come through the early critical period there is no reason to expect that they will now need to rely upon anything other than their own proven resources as they continue to expand their operations in accordance with the reasonable expectations.

The Indiana Blue Shield Plan which was started in 1946 should go over the 1,000,000 members enrolled during this year. The plan has never raised its premium on its enrolled groups and has increased its payment to the subscriber three times. We are now working on a new contract with a higher fee schedule which is more in line with present day fees. This contract with a higher premium will not supplant the old contract but will be sold to interested groups. Many groups are demanding a contract that has a higher fee schedule.

As a final thought, people must remember that in these times of skyrocketing costs that they are still only paying four cents out of each dollar for their medical care, the same proportion their parents spent for medical care 20 years ago.

*Wm Harry Howard M.D.*

# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

The House of Delegates, with its excitement and fanfare, is now over, and it is my privilege to bring greetings JOURNAL readers in the name of the new officers and committee chairman for 1954-1955. We pledge to you our support during the year to come.

At this time I wish to pay tribute to the president who preceded me, Mrs. W. Burleigh Matthew—Sue, to her Auxiliary friends. I believe that Auxiliary, in both thought and deed, filled most of her waking hours during the past year, and she probably dreamed Auxiliary in her sleep! To me she has been most helpful and understanding. She took much of her precious leisure time to write me notes and letters, briefing me on different phases of Auxiliary work that often had come as a complete surprise to her. If I am lax or forgetful of any matter that should require my attention, it surely will be no fault of hers. I am most grateful.

### Highlights of Our Convention

Our charming National President, Mrs. Leo J. Schaefer, spent one day with us and gave a most inspiring address. She proudly announced that the Auxiliary had been accorded national recognition when she was asked to serve on the White House Conference on Highway Safety, called by President Eisenhower. On invitation of Ivy Baker Priest, treasurer of the United States, she served on the planning committee for the woman's division.

She asked that we continue our work in nurse recruitment, voluntary health insurance, civil defense, health legislation, Today's Health, and American Medical Education Foundation. She also said, "The auxiliary meeting is your school, the Bulletin is your textbook, and Today's Health magazine is your means of disseminating authentic health information."

Mrs. Francis Fargher, our American Medical Education Foundation chairman, awarded a blue ribbon to the Marion County Auxiliary for the largest contribution this year. Mrs. F. M. Gastineau, National Chairman of A.M.E.F., pinned the ribbon on the president, Mrs. Morris B. Paynter. Vanderburgh County received honorable mention as second highest contributor.

Randolph County received the award (an orchid) for the highest contribution, on a percentage basis. Its members contributed \$120, or six and two-thirds dollars per member.

The entire membership of the House of Delegates was delighted to honor Mrs. D. E. Lybrook, a past state president, and our present Rural Health Chairman, who was recently named "Indiana Mother of the Year."

We shall be better informed auxiliary members after hearing Dr. I. Lynd Esch, President of Indiana Central College, give his talk on "Federal Aid to Education."

We were happy to have as our dinner guests, Dr. Walter L. Portteus, President-Elect, I.S.M.A., and Mr. James A. Waggener, Executive Secretary, I.S.M.A. Also, our luncheon guests, Dr. Russell J. Spivey, President, and Mr. Joseph E. Palmer, Executive Secretary of the Marion County Medical Society.

The reports of the county presidents and committee chairmen were interesting and inspiring. They showed a diversity of achievement in every field of Auxiliary work.

And now, the new year is before us. The page is now blank. By next April, we hope to have it filled to overflowing with even greater and better accomplishments.

"If you would leave footprints on the sands of time, you must put on work shoes."

I challenge all Auxiliary members to "Put on work shoes."

Mrs. Harry C. Harvey.



# GG DISTRIBUTION CRITERIA AND CENTERS LISTED BY BOARD OF HEALTH

The following bulletin and information was recently issued to every practicing physician in the State of Indiana by the State Board of Health. It is published here to emphasize the importance of being familiar with the criteria for distribution and to furnish the list of distribution centers.

The bulletin on the subject "Gamma Globulin" follows:

The distribution of gamma globulin during the coming year is to be administered as it was in 1953. Attached you will find new criteria for the issuance of gamma globulin which acts to extend the group who may receive this material.

For your convenience, there is attached an application form with the same criteria printed on the reverse side.

Because of the wide-spread immunity to measles which is to be found in those persons who reach adult life, we would like to be informed of the medical reason requiring its use in all patients over sixteen years of age. Your attention is invited to the fact that the new criteria are sufficiently flexible to allow for complete medical judgment as to whom shall receive gamma globulin.

## TECHNICAL BULLETIN STATE BOARD OF HEALTH

No. 1

March 11, 1954

### Criteria for Distribution of Gamma Globulin upon Physician's Request

#### MEASLES:

1. *Modification* dose of 0.02 cc. per pound of body weight regardless of age, *at discretion of physician.*
2. *Prevention* dose of 0.10 cc. per pound of body weight, *at discretion of physician for:*
  - (a) Children under one year of age regardless of state of health.
  - (b) Children over one year of age convalescing from recent illness or having chronic disease—*provided that maximum issued for these reasons shall be limited to 10 cc.*
3. *Pregnancy*—Individuals exposed to Rubella (German Measles) or with negative history of Rubella (Measles) may be given a *maximum dose of 10 cc.*

#### INFECTIOUS HEPATITIS:

To be issued only to intimate familial contacts\* for prevention.

Dosage 0.02 cc. per pound of body weight. *Not for treatment.*

#### POLIOMYELITIS:

1. Intimate familial contacts\* under 30 years of age.
2. Pregnancy—any age.

3. Dosage 0.14 cc. per pound of body weight with maximum issued for any one individual 20 cc.

Depots authorized to issue gamma globulin only as above. Unusual requests for other diseases must be referred to Division of Communicable Disease Control, Indiana State Board of Health, for consideration.

Note—Gamma globulin processed from placentas is reddish brown in color due to minute portion of hemoglobin remaining.

#### Indiana State Board of Health Distribution Centers for Immune Serum Globulin

COLUMBUS—William B. Sigmund, M.D., Bartholomew Co. Hospital

EAST CHICAGO—H. C. Ernst, M.D., City Hall

ELKHART—I. J. Markle, M.D., 202 Harrison Street

EVANSVILLE—Minor Miller, M.D., Evans.-Vand. County Health Dept., 201 S. E. Third Street

FORT WAYNE—Walter E. Kruse, M.D., City Hall

GARY—Frank J. Kendrick, M.D., 1429 Virginia Street

HAMMOND—F. A. Musacchio, M.D., City Hall

INDIANAPOLIS—Henry G. Nester, M.D., City-County Health Dept., City Hall

JEFFERSONVILLE—H. H. Reeder, M.D., 332 Spring Street

KOKOMO—R. W. Phares, M.D., 113½ Mulberry Street

LAFAYETTE—Sister Vera, St. Elizabeth's Hospital

LAPORTE—C. H. Elshout, M.D., 1004 Indiana Avenue

LAWRENCEBURG—W. J. Fagly, M.D., 238 Short Street

LOGANSPOUT—J. J. Stanton, M.D., City Building

MARION—A. Ward Bloom, M.D., 724 West Third Street

MICHIGAN CITY—D. G. Bernoske, M.D., Court House

NEW ALBANY—William E. Amy, M.D., 1801 Ekin Avenue

PRINCETON—Charles A. Miller, M.D., 117 South Hart Street

RICHMOND—W. R. Taylor, M.D., 308 Medical Arts Building

SOUTH BEND—F. R. N. Carter, M.D., City Hall

SHELBYVILLE—Wilson L. Dalton, M.D., 301 Methodist Building

TERRE HAUTE—M. M. Rubin, M.D., City Hall

VINCENNES—John B. Anderson, M.D., 418½ Main Street

WARSAW—Ryland Roesch, M.D., Court House

#### \* INTIMATE FAMILY CONTACT DEFINED:—

Member of same household and/or family; individuals visiting home of primary case for at least eight hours so that intimate contact was prolonged. *Does not include school room contacts, church contacts, neighborhood groups, etc.*

## AUXILIARY HOUSE OF DELEGATES HEARS REPORTS, INSTALLS OFFICERS

**D**ELEGATES to the Tenth Annual House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association met April 6 and 7 in the Lincoln Hotel, Indianapolis.

Highlights of the two-day session were addresses by Mrs. Leo J. Schaefer, president of the Woman's Auxiliary to the American Medical Association; the committee reports, including the President's report by Mrs. W. Burleigh Matthew; a memorial service for members who have died during the last year; and the installations of the 1954-55 officers by Mrs. Charles E. Voyles, Indianapolis.

Climax of the conference was the inaugural address of Mrs. Harry C. Harvey, Fort Wayne, president for the coming year.

One hundred and sixty-three delegates were registered and there were a number of special guests.

The Auxiliary to the Indianapolis Medical Society made session arrangements. Mrs. Morris B. Paynter, was general chairman; Mrs. Ralph Everly and Mrs. Dan E. Talbott, were in charge of food reservations; Mrs. Howard S. Williams, registration; Mrs. Bernard D. Rosenak, Mrs. Byron K. Rust and Mrs. Myron H. Nourse, hospitality; Mrs. Gordon W. Batman, decorations; Mrs. Thomas Cortese, favors and prizes; Mrs. Earl W. Mericle and Mrs. Dwight W. Schuster,

entertainment; and Mrs. Ted L. Grisell, printing and mailing.

The impressive ceremony at the Memorial Breakfast was read by Mrs. Morris B. Paynter, president of Indianapolis Auxiliary after which the "Lord's Prayer" was sung by Mrs. C. Basil Fausset, accompanied by Mrs. Russel Lamb. Both are members of Indianapolis Auxiliary.

The House of Delegates voted to make a lump contribution to the American Medical Education Foundation to honor all deceased members for 1953-54.

The 16 Auxiliary members so honored were: Mrs. E. A. Rainey, Lebanon (Boone County); Mrs. Hamilton M. Arthur, Hazelton (Gibson); Mrs. C. E. Canaday, New Castle (Henry); Mrs. Charles F. Leich, Evansville (Vanderburgh); Mrs. O. T. Allen, Terre Haute (Vigo); Mrs. Frank E. Sayers, Terre Haute (Vigo); Mrs. Robert N. Kabel, Terre Haute (Vigo); Mrs. L. C. Lukemeyer, Huntingburg (Dubois); Mrs. Ross Ottinger, Indianapolis (Marion); Mrs. John W. Kistner, Elkhart (Elkhart); Mrs. W. E. Smith, Decatur (Adams); Mrs. D. J. Cummings, Brownstown (Jackson-Jennings); Mrs. Allen Nickel, Bluffton (Wells); Mrs. W. U. DuVall, Mishawaka (St. Joseph); Mrs. F. T. Tyler, New Albany (Floyd); Mrs. Verne L. Turley, Fowler (Benton).

Past presidents of the Indiana Auxiliary pose with Mrs. Leo Schaefer, national Auxiliary president. Seated, from left to right are Mrs. Matthew; Mrs. Frank M. Gastineau, Indianapolis; Mrs. Schaefer; Mrs. D. E. Lybrook, Young America; Mrs. F. M. Fargher, Michigan City; Standing, left to right are Mrs. Hubert T. Goodman, Terre Haute; Mrs. C. E. Voyles, Indianapolis; Mrs. Truman Caylor, Bluffton; Mrs. A. W. Ratcliffe, Evansville.

Mrs. W. Burleigh Matthew, Indianapolis, retiring Auxiliary president, presents her successor in office, Mrs. Harry C. Harvey, Fort Wayne, to the House of Delegates.



## President's Report to the House of Delegates, Woman's Auxiliary, Indiana State Medical Association

The following report was presented by Mrs. W. Burleigh Matthew, president, at the Tenth Annual House of Delegates of the Woman's Auxiliary in the Hotel Lincoln, Indianapolis, April 7, 1954.

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Following the House of Delegates meeting last April, 1953 your President was immediately confronted with all the questions and problems of the Auxiliary, and it was soon realized that there was much to be done and much to be learned, and that the responsibility that went with this honor would require all of one's time, energy and thought.

Attending the National Convention in New York the President had the opportunity of hearing state reports (which were made up from individual county reports condensed into one final combination national report.) It was then realized more than ever that Indiana, and in turn its individual counties, are most important cogs in the wheel of progress of the National Auxiliary. This year we have made great progress with our program, not through the outstanding achievements of one county, but through the combined efforts of all 65 counties working together for one goal—better public relations for the medical profession.

This year for the first time late in June the President invited all 23 State Committee Chairmen and State Officers to attend a general meeting so they could become better acquainted and have an opportunity to exchange ideas regarding the presentation of the program to the counties. Our program was sent to all auxiliaries in July, and all chairmen included letters of information and instruction. It was felt much was gained through the assembly of this group and they again met at the State Convention to discuss the progress of the program and suggestions for improvement. In September the Executive Committee met with the Advisory Committee of the State Medical Association at which time the Auxiliary program was presented

and was given the approval of the Medical Association. The A.M.A. publication, *Today's Health*, has had a definite increase in popularity this year and Indiana was honored when the following counties, Perry, Randolph, Porter, Lawrence, Kosciusko, Floyd and Elkhart, received national recognition for their outstanding records.

Again this year our sales have increased for the national publication, "*The Bulletin*," and through it we are kept well informed on all the activities of other states as well as the National Auxiliary.

Our own publication, "*The Hoosier Doctor's Wife*" managed to come through with its usual spring, summer, fall and winter issues, although it was faced at the beginning of the year with a cut in its budget of \$800.00 as well as reduction in its size. Nevertheless it continued to bring us promptly the state and county news and to serve as a means of communication between our counties and the state organization. It has been the pleasure of the President to receive many complimentary letters regarding the revised publication.

We are still prepared to give our full attention to Civil Defense when we are called upon. Many of our counties are taking active part in the local programs.

Quite a number of our Auxiliaries have organized legislative discussions or legislative study groups and this year our counties have been kept well informed on all legislative matters. The A.M.A. sponsored Washington Newsletter continues to be very popular and interesting to all. Many of our counties sponsor radio programs with A.M.A. platters.

Our A.M.E.F. report is not complete as yet but we are happy to have a total report of \$2,934.19 to date which shows a marked increase over our contribution of last year; we are pleased to see more individual counties have contributed this year which makes us realize more than ever that the Hoosier Doctors' Wives are opposed to Federal Aid to Education and are willing to do their part to



fight it. Our "In Memoriam Cards" for A.M.E.F. were introduced at our convention in the fall and it has been quite encouraging to see how they have been received by the Auxiliaries. In November at the Annual Presidents and Presidents-Elect Conference as a member of the A.M.E.F. panel your President presented the "In Memoriam Cards" to all of the delegates attending, and it was with great pride that we have since learned that the National office has had printed exact duplicates of our A.M.E.F. Cards which will be used by auxiliaries in the United States, Hawaii and Alaska.

We sponsored one Rural Health meeting held at Russiaville and at the direction of our parent organization, the Medical Association, called a meeting to discuss the proposed "Health Forums."

When we speak of Public Relations we speak of all phases of our program and it would be impossible to select one outstanding project or one outstanding county for this past year since it takes the combined efforts of all 65 auxiliaries with the support of all 2,387 individual members. We have found that the majority of our organizations are vitally interested in Nurse Recruitment and this was much in evidence when we assembled the reports of those counties which returned the requested information. We learned that:

27 counties assisted 46 girls through



Additional groups, right, are pictured at the April Auxiliary convention in Indianapolis.

Top, Mrs. W. B. Matthew, president; Miss Barbara Jean May, Brookston, recipient of this year's scholarship to a 4-H girl entering nurses' training. Miss May will enter Methodist Nurses Training School in the fall. Others are Mrs. D. E. Lybrook, who as president instituted the scholarship program; and Miss I. Resh, Centerville, a junior at Methodist and recipient of the first scholarship.

The second group includes Mrs. Harvey, 1954-55 president; Dr. Elton R. Clarke, Kokomo, chairman of I.S.M.A. Council; and Mrs. Roy W. Myers, Indianapolis. Mrs. Matthew, Mrs. W. L. Porttens, Franklin; Mrs. Myers; and Dr. W. B. Matthew are in the next group. Bottom picture is of Dr. Roy W. Myers, Indianapolis, treasurer of I.S.M.A.; Dr. Walter L. Porttens, Franklin, president-elect, and Dr. I. Lynd Eseh, president of Indiana Central College, who was speaker at the annual Auxiliary banquet.

Loans, Gifts and Scholarships spending -----	\$7,386.00
1 State 4-H scholarship was awarded representing all the Auxiliaries----	100.00
1 county donated to Cerebral Palsy hospital -----	18.50
1 county donated to State Nurses Convention -----	50.00
15 counties held Nurse Recruitment Teas (entertaining 72 high school girls) -----	250.95
3 counties took Nurse Recruitment films to county schools-----	10.92
1 county sponsored nurses dance ----- (no expense reported)	
1 county played hostess for dinner for all Senior Nurses ----- (no expense reported)	
Total spent -----	\$7,716.37

Six counties have plans ready for first scholarship this year.

This year the Medical Association voted to give us monthly a full page in *THE JOURNAL* and if we can train our husbands to share the publication with us it will mean another means of communication as well as informing all the doctors of the part we are playing in

the public relations field. For some time the Auxiliary membership roster has been carried in the July copy of *THE JOURNAL*.

Your president attended 11 district meetings, 1 organization meeting, 2 conferences in Chicago, the National Convention held in New York, 15 County Auxiliary meetings, gave the annual report to the House of Delegates of the Indiana State Medical Association, attended the Indiana Public Health Conference, Rural Health Program held at Purdue University, Rural Health meeting at Russiaville, the Health and Safety Conference at Purdue University, attended the all day meetings for Civil Defense, and the Governor's Conference on Child Health and Welfare. This meeting will conclude her duties as State President but according to precedent set in the past she will present at San Francisco the final report of the year for Indiana. At the conclusion of her tour of duty she will have travelled about 12,000 miles.

To all county presidents, state committee chairmen, state officers, district councilors and to each auxiliary member may we say "Thank You" for all you have done this year to make our Auxiliary progress just a little more toward bigger and better objectives.

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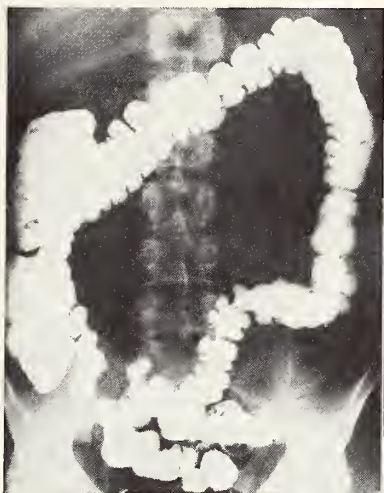
**DISHPAN HANDS.** The condition "dishpan hands" is no more than a reaction to exposure to irritants and sensitizers in daily household chores, according to Mrs. Veronica Conley, Chicago, assistant secretary of the American Medical Association's Committee on Cosmetics. In addition to their unattractiveness, such hands may be the danger signal that more serious trouble is not far off, she added.

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And we've been told about the fellow who had to travel about the country a great deal but refused to fly because of his "religion." When he was asked, "What religion?" his reply was, "I'm a devout coward."—**Sam Ragan, News and Observer.**



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It is indicated in chronic constipation of various types—including distal colon stasis of the

"irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined muciloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

## THE MONTH IN WASHINGTON

Washington, D. C.—These spring days are growing into weeks that really count in Congress. Unless a bill deals with an emergency, it had better be well on its way through committees by now or its chances of enactment will fade rapidly as summer approaches.

For good or evil, a large amount of health legislation is well advanced, and if Congress holds to an average pace several bills affecting the medical profession are likely to become law in the next month or so. Here is the situation in brief:

**MEDICAL DEDUCTIONS.** Legislation to increase the amount deducted from taxable income for medical expenses is a part of the omnibus tax revision bill which cleared the House early and by a wide margin, but ran into some delay on the Senate side. This bill, with the medical deduction liberalization intact, should reach the White House in plenty of time.

**HILL-BURTON EXPANSION.** A move to make important changes in this bill developed in the Senate Labor and Welfare Committee, after the House had passed its version with some amendments. American Hospital Association proposed that the rather complicated House legislation be scrapped, and instead that the Hill-Burton Act be amended to (a) include rehabilitation centers and nursing homes, and (b) place a high priority on hospitals for the chronically ill. The AHA idea immediately attracted support in and out of the committee. The new approach suggested by AHA meant inevitable, but probably not fatal, delays.

**REINSURANCE.** This proposal, once hailed as the keystone of the Eisenhower administration's health program, continued to encounter opposition. At one stage, of all the national associations to testify on reinsurance only American

Hospital Association was giving it unqualified support. American Medical Association, the U. S. Chamber of Commerce, and national spokesmen for the insurance industry took about the same position: 1. Reinsurance alone cannot make uninsurable risks insurable. 2. The threat of federal control of medicine is inherent in any program that would bring the federal government in such close contact with medical practice. Dr. David B. Allman, representing the AMA at the House hearings, emphasized that the Association would welcome and cooperate in any movement carrying real promise of promoting voluntary health insurance.

**HEALTH GRANTS.** This is an administration plan to do away with the present categorical grants for identified projects, such as venereal disease control, and to substitute funds earmarked for three general purposes, (a) to maintain present programs, (b) to initiate new programs or to expand existing ones, and (c) to finance public or private experimental or pilot programs of national or regional significance. In both committees, the question was whether to group the first and second type grants together, with the state health authorities deciding how to divide up the federal money among old and new projects. Funds for the third type grant—experimental—would be completely controlled by the surgeon general. One suggestion is to require approval of the state health officer for any experimental (type three) grant in his state. Another is to eliminate the third type grants altogether, letting the National Institutes of Health handle public health as well as other medical research grants.

**SOCIAL SECURITY.** American Medical Association, American Dental Association and a number of other national groups are fighting vigorously to prevent compulsory extension of

Old Age and Survivors Insurance to physicians, dentists and most other self-employed. Instead, they want the privilege of deferring income tax payments on that part of earnings placed in restricted annuities—the Jenkins-Keogh plan. AMA also feels that there is no need for the bill's provision that pension rights be frozen during periods when the worker has been medically determined to be disabled. A better suggestion, the Association maintains, is to base pension rates on the ten best working years, thus virtually eliminating the need for the controversial medical examinations. Prospects are good that social security will be extended, either with or without these changes.

**VOCATIONAL REHABILITATION.** Generally, Senate witnesses favor the administration's proposal to expand the federal-state

programs, providing U. S. grants aren't cut. However, with no House bill introduced as of this writing, there is some doubt that, even if the Senate clears the measure, the House can find time to deal with it.

**DOCTOR DRAFT AMENDMENT.** This bill, an outgrowth of the Peress case, swept through the Senate without objection. It may be law by the time this is published. It would amend the Doctor Draft act to permit the services to keep on duty as an enlisted man, assigned to professional tasks, anyone called under the Doctor Draft act whose loyalty is questioned. Defense Department has promised to investigate such cases immediately, so that the man can be cleared promptly and offered a commission or discharged. The discharge would state that action was taken on loyalty grounds.



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On the basis of clinical investigations to date, ACHROMYCIN is indicated in the treatment of beta hemolytic streptococcic infections, *E. coli* infections, meningococcic, staphylococcic, pneumococcic and gonococcal infections, acute bronchitis and bronchiolitis, and certain mixed infections.

CAPSULES { 250 mg.  
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INTRAVENOUS { 500 mg.  
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SPERSOIDS\* { 50 mg.  
Dispersible { per teaspoonful  
Powder      { (3.0 Gm.)

Other dosage forms will become available as rapidly as research permits.

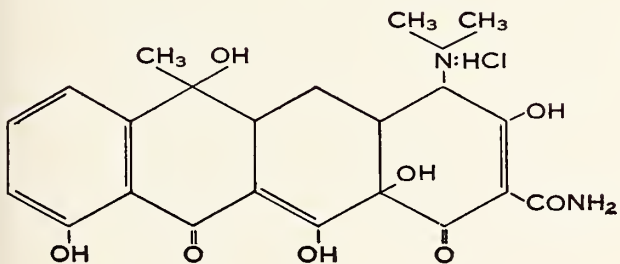
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## Deaths . . .

**James Charles Carter, M.D.**, 68, Indianapolis pediatrician for many years, died in his home March 20 following an extended illness during which he was in semi-retirement.

A native of Shelby County, Doctor Carter was a graduate of DePauw University and received his medical degree in 1913 from Harvard Medical School, Boston. He served as a lieutenant in the Army Medical Corps during World War I then came to Indianapolis where he had practiced since.

Doctor Carter, a certified pediatrician, was active for many years on committees of Indiana State Medical Association dealing with maternal and child health problems. From 1936 through 1941 he was on the State Division of Public Health Liaison Committee to deal with the Social Security Act and a Subcommittee to Study Maternal Morbidity and Mortality Rates for Indiana. From 1942 through 1946 he was on the Advisory Committee to the Bureau of Maternal and Child Health, Indiana State Board of Health.

He had church, fraternal and military organization affiliations; was a member of Indianapolis Medical Society, the state and national medical associations and the American Academy of Pediatrics.

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**Clyde S. Carmichael, M.D.**, 77, who had practiced medicine in the small town of Seelyville in Vigo County for almost 50 years, died in Union Hospital, Terre Haute, March 6, following a two-week illness. Doctor Carmichael went to Seelyville following his graduation from the Medical College of Indiana at Indianapolis in 1905. His practice there was interrupted briefly for postgraduate work in New York and while he served as a first lieutenant in the Army Medical Corps during World War I.

Doctor Carmichael was past president of the Vigo County Medical Society and of the Fifth District Medical Society. He had also

served as president of the staff of Union Hospital, Terre Haute.

In addition to his membership in medical organizations including his county, state and national associations and the Aesculapian Society, Doctor Carmichael held church and lodge memberships and participated actively in those groups.

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**James M. Smith, M.D.**, 70, former Indianapolis physician, died March 16 at his country home near Nashville, Brown County. A native of Ohio, Doctor Smith was a member of the first graduating class of Indiana University School of Medicine in 1908. He served as an insurance examiner in Indianapolis for many years and at the time of his death was medical advisor for the Blue Cross Plan in Brown County. He was a former health officer of that county.

Doctor Smith served as a captain in the Army Medical Corps overseas during World War I. He was a member of Indianapolis Medical Society and the Indiana State Medical Association.

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**Edmund Carl Hack, M.D.**, 66, Hammond physician for 31 years, died in St. Margaret's Hospital, Hammond, March 13. He had been on the hospital staff since 1923. He had suffered a heart attack in 1948 and had been in ill health since that time, although he had maintained his private practice of medicine and continued his duties on the hospital staff.

Doctor Hack was a graduate of Bennett Medical College, Chicago, which later became a part of Loyola University. He received his degree there in 1911. He was a member of Lake County Medical Society, the Indiana State and American Medical Associations and had been active in Masonic affairs.

# Meats-in-a-Can

## *and Kitchen-Cooked Meats...*

### *Comparative Nutritive Values*

From a practical dietary standpoint, meats-in-a-can—preserved by commercial canning—are nutritionally interchangeable with meats of like variety prepared in the home.<sup>1</sup> For taste appeal, for economy and “keeping” quality, and for household con-

venience, meats-in-a-can are advantageous in many respects.

As the comparative data here shown indicate, kitchen-prepared meats and similar meats-in-a-can are closely alike in the amounts of various nutrients they provide.

COMPARATIVE COMPOSITION OF KITCHEN-COOKED AND COMMERCIAL-CANNED MEATS  
(Nutrient Amounts per 100 Grams)

	*Kitchen-Cooked Ham <sup>2</sup>	**Canned Ham <sup>3</sup> (Chopped, Cured)	Kitchen-Cooked Beef Round <sup>2</sup>	Canned Roast Beef <sup>2</sup>
Water	50%	50%	59%	60%
Protein	21 Gm.	20 Gm.	27 Gm.	25 Gm.
Fat (ether extract)	28 Gm.	20 Gm.	13 Gm.	13 Gm.
Niacin	4.0 mg.	4.3 mg.	5.5 mg.	4.2 mg.
Riboflavin	0.21 mg.	0.19 mg.	0.22 mg.	0.23 mg.
Thiamine	0.46 mg.	0.40 mg.	0.08 mg.	0.02 mg.

\*Values after conversion from 42% to 50% water basis.

\*\*Values after conversion from 58.69% to 50% water basis.

Experimental studies have shown that the processing which meats-in-a-can undergo leads to little if any greater vitamin losses than does home-cooking of similar cuts of meat. In general, meats-in-a-can retain of their original vitamin content approximately:

- 60 to 80 per cent of thiamine
- 90 to 100 per cent of riboflavin
- 90 to 100 per cent of niacin
- 80 per cent of biotin
- 70 to 80 per cent of pantothenic acid.<sup>4,5</sup>

During storage for customary periods, at usual warehouse temperatures, meats-in-a-can show little, if any, further vitamin loss except in thiamine. Even thiamine, a highly thermolabile vitamin, was 52 per

cent retained in pork-in-a-can after ten months' storage at 80° F. Retention of the vitamin was notably greater when the canned pork was stored at 38° F.

Since meats-in-a-can are thoroughly cooked in processing, they may be consumed as purchased, merely warmed or mildly cooked. When the meat is moderately cooked in preparation for consumption, little or no further loss in vitamins need to occur.

Recent studies show that meats-in-a-can are excellent sources of needed amino acids.<sup>6</sup> The 18 amino acids determined in these studies appeared in similar ratio and amounts in canned beef, pork, and lamb as in the respective fresh or home-cooked meats.

1. Howe, P. E.: Foods of Animal Origin, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 637.

2. Watt, B. K., and Merrill, A. L.: Agricultural Handbook No. 8, United States Department of Agriculture, 1950.

3. Schweigert, B. S.; Bennett, B. A.; Marquette, M.; Scheid, H. E., and McBride, B. H.: Food Res. 17:56 (Jan.) 1952.

4. Rice, E. E., and Robinson, H. E.: Am. J. Pub. Health 34:587 (June) 1944.

5. Schweigert, B. S.: Am. Meat Inst. Foundation, Circular No. 8, Nov. 1953.

6. Schweigert, B. S.; Bennett, B. A.; McBride, B. H., and Guthneck, B. T.: J. Am. Dietet. A. 28:23 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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**Harry E. Nave, M.D.**, 86 year old physician who had practiced in Fountaintown, Shelby County, for more than 50 years, died in the W. S. Major Hospital, Shelbyville, March 15, following a brief illness. He had retired from active practice.

Born in Shelby County in 1877, Doctor Nave spent his life in that county. He received his medical degree from the Eclectic Medical College of Indiana at Indianapolis in 1905. He was a 50-year member of Shelby County Medical Society and a member of the Indiana State Medical Association.

**John E. Luzadder, M.D.**, 84, whose 45 years of practice set a record in Bloomington, died in Bloomington March 22. He had been in ill health and in semi-retirement for three years.

A native of Bloomington, Doctor Luzadder was graduated from Kentucky School of Medicine, Louisville, in 1891. He practiced for a brief time at Smithville, also in Monroe County, before going to Bloomington in 1909. He was a senior member of Owen-Monroe

County Medical Society and a member of Indiana State Medical Association.

Dr. Luzadder was the father of John E. Luzadder, Jr., M.D., New Carlisle.

**Clarence Hill, M.D.**, 80, a resident of Frankfort for 57 years, died suddenly in his home there March 19. Doctor Hill was a native of Logansport and received his medical degree in 1898 from the Medical College of Indiana at Indianapolis. He was licensed that year and established his office in Frankfort where he had remained in the same location. Doctor Hill was presented a certificate from the Indiana State Medical Association in recognition of his 50 years of ethical practice in Frankfort.

**William F. Houk, M.D.**, 77, who retired from active practice in Crown Point in 1950, died February 26 at the family's winter home in Miami, Florida, following a month's illness. He was a 1904 graduate of the Univer-

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A selective alkaloidal extract of hypotensive principles obtained by fractionation from *Veratrum viride*. Representing less than 1% of the whole root, it is freed from the dross of the mother substance. It is generically designated alkavervir. In the management of hypertension it presents these desirable properties.

**1** Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.

**2** Blood pressure is lowered by centrally mediated action; there is no ganglionic or adrenergic blocking.

**3** Therapy is rarely, if ever, fraught with the danger of postural hypotension.

**4** Hypotensive action is independent of alterations in heart rate.

**5** Cardiac output is not reduced.

**6** Renal function, unless previously grossly reduced, is not compromised.

**7** Cerebral blood flow is not decreased.

**8** Cardiac work is not increased, tachycardia is not engendered.

**9** No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily over-

come and thereafter avoided by dosage adjustment.

**10** In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.

**11** Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

**12** Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

**13** Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

**14** A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

## Tablets Veriloid

The slow-dissolving, scored tablets are supplied in 2 mg. and 3 mg. potencies. In moderate to severe hypertension they produce gratifying response in many patients. According to published reports<sup>1</sup> this response can be maintained for long periods in fully 30% of patients; combination with other hypotensive agents has been credited with greatly increasing this percentage.<sup>2</sup> Initial daily dosage 9 mg., given in divided doses, not less than 4 hours apart, preferably after meals. To be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose 9 to 24 mg. daily.

## Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), the toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety.<sup>3</sup> If excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

## Solution Intramuscular

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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of

Intravenous Administration of a Preparation of *Veratrum Viride* in Patients with Severe Forms of Hypertensive Disease, *New England J. Med.* 246:397 (Mar. 13) 1952.

4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, *Am. J. M. Sc.* 226:477 (Nov.) 1953.

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sity of Illinois College of Medicine, Chicago. Doctor Houk established his practice in Crown Point that year. He served as a medical examiner during both World War I and II and was a Lake County deputy coroner for 20 years.

**Henry B. Shacklett, M.D.**, 82, who was a physician in New Albany for 50 years prior to his retirement in 1953, died March 11 in his home in Mobile, Alabama. Doctor Shacklett was born in Brandenburg, Kentucky and received his medical education at the Louisville Medical College where he was graduated in 1896. He was a veteran of World War I. Doctor Shacklett was a former president of Floyd County Medical Society and at the time of his death was a senior member and a 50-year member of Indiana State Medical Association. He was an associate member of American Medical Association. He was also a 50-year

member of the Masonic order and affiliated with several New Albany clubs and lodges.

**Joseph C. Manning, M.D.**, Indianapolis surgeon who at 31 collaborated on work on an artificial kidney used in surgery which brought him recognition for his contribution to medical science, died April 3 at Shepard Air Force Base, Wichita Falls, Texas, where he had been hospitalized since January. He was 37 years old.

Doctor Manning, a native of Missouri, received his medical education at the University of Missouri Medical School and at the University of Tennessee College of Medicine, Memphis, where he received his degree in 1942. From 1945 to 1948 he served a residency at Indiana University Medical Center. He was in private practice in Indianapolis engaged in general surgery.

In March, 1953, Doctor Manning joined the Air Force and from April until January when

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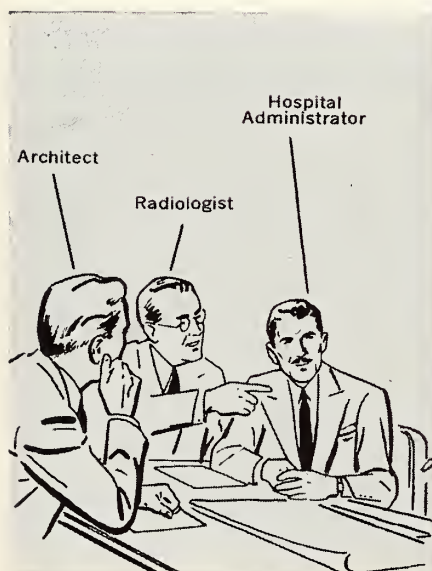
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he became seriously ill was in charge of surgery at Tinker Air Force Base, Oklahoma City, Oklahoma. He went to Shepard Field for surgery. His brother, K. R. Manning, M.D., also of Indianapolis, is in charge of orthopedic surgery at that base.

Doctor Manning was a fellow of the American College of Surgeons, a member of Indianapolis Medical Society, the Indiana State and American Medical Associations and had civic club and church affiliations in Indianapolis.

**James Roger Ware, M.D.**, 41, died April 1 in his home in Huntington a few minutes after suffering a heart attack upon arising in the morning. He had not been ill.

Doctor Ware was a native of Wells County, attended Huntington schools, and received his medical degree in 1939 from Indiana University School of Medicine. He interned in Madison, Wisconsin, then returned to Indiana and established an office for the general practice of medicine in Andrews. In June, 1942 he enlisted in the Army ground forces and served

three years, much of the time in the Pacific theatre of operations. He attained the rank of major prior to his release from service.

After returning from service Doctor Ware established his office in Huntington. He was a member of Huntington County Medical Society, the Indiana State and American Medical Associations, and also had church and lodge affiliations.

**William E. McCool, M.D.**, retired Evansville physician and surgeon, died in his home March 31 following a six-month illness. Doctor McCool who was 85, practiced medicine in Vanderburgh County for 50 years before going into semi-retirement in 1942.

The veteran physician was a native of Warlick County, received his degree in medicine from Rush Medical College, Chicago, in 1890 and did postgraduate work in New York and at the Mayo Clinic.

Specializing in industrial practice, Doctor McCool had retained his positions as district surgeon for the C.E. and I. Railroad and as surgeon for Hoosier Cardinal Corporation. He was assisted by his son, Joseph H. McCool, M.D.

Doctor McCool was a senior member of Vanderburgh County Medical Society, a 50 year club member of Indiana State Medical Association, and associate member of American Medical Association. He was also a member of the American College of Surgeons, American Railway Surgeons and the American College of Industrial Physicians and Surgeons. He had active Masonic order and church affiliations and formerly was associated with Welborn, Deaconess, St. Mary's and Boehne Hospitals, Evansville.

**Ira M. Washburn, M.D.**, 79, retired Rensselaer physician, died April 7. He received his medical degree in 1900 from Rush Medical College, Chicago. After many years of practice in Rensselaer, Doctor Washburn retired in 1946. He was a member of the 50 Year Club of Indiana State Medical Association. Doctor Washburn was the father of Dr. Richard Washburn, former Rensselaer physician, now practicing in Illinois.

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# NEWS NOTES — from State and Nation

## **Chest Disease Symposium For GP's at Saranac**

The third annual Symposium on Tuberculosis and other Chronic Pulmonary Diseases for General Practitioners will be held at Saranac Lake, New York, from July 12 through July 16. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the American Trudeau Society, the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is \$40 for A.A.G.P. members and \$50 for non-members.

The scope of this year's meeting has been broadened to include nontuberculous pneumonias, pulmonary cancer, lung abscess, fungus diseases, bronchiectasis, sarcoid, cystic disease, emphysema, and the pneumoconioses.

Complete information may be obtained from Richard P. Bellaire, M.D., Chest Disease Symposium, Box 2, Saranac Lake, New York.

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**Dr. Frederic H. Wood**, who has been in practice in Hammond opened an office April 1 in the Morris-Pioneer Building, 1224 Manatee Avenue, Bradenton, Florida.

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**Dr. Elmer Michael Truman, Jr.** will open an office June 1 for the general practice of medicine at 814 Main Street, Brookville, Indiana. Doctor Truman has been assistant chief of obstetrics and gynecology at Lockbourne Air Force Base Hospital, Columbus, Ohio for the last 13 months. Prior to entering military service, Doctor Truman was in practice in Rushville.

**Dr. Young Dai Kim**, 136 North 17th Street, Beech Grove, recently received his citizenship papers in Federal court at Indianapolis. He is the first native-born Korean to become an American citizen in Indiana. Dr. and Mrs. Kim both came to the United States as children but were not eligible to become citizens until after passage of the McCarran Act in 1950. Mrs. Kim also received her final papers.

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## **Appointees to Medical School Are Announced**

Dr. Warren E. Coggeshall has been named an instructor in medicine at Indiana University School of Medicine. Other appointments recently disclosed include that of Dr. William M. Loehr as part-time associate professor of radiology and L. L. A. Moore, Jr., who has been advanced from a teaching assistant on the medical school faculty to instructor in microbiology.

Also included in the announcement was Mrs. Helen Onyett, registered medical technologist, who was named clinical instructor in communicable diseases for the nurses school.

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**Henry County registered nurses** recently heard a talk by Dr. Robert Davies, New Castle, on "Nerve Gas" as part of their course in civil defense. Members of the New Castle police department, service clubs, first aid unit and city officials were guests in addition to 30 nurses.

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Announcement has been made by the Awards Committee for Schering Corporation that the three winning papers in the **1953 Schering Award competition** were written by Irvin Paul Pollack, University of Maryland; Frank Edward Young, Syracuse College of Medicine, New York; and George Richard Pieper, University of Utah College of Medicine.



## 7 Indiana Auxiliaries Receive Commendation

High praise was voiced by Edward J. McCormick, M.D., president of American Medical Association, of the efforts of many Auxiliaries throughout the United States whose members are promoting Today's Health. Doctor McCormick spoke at the National Conference of Auxiliary Officers. Today's Health, written for the general public, is a year round health education project of the Auxiliary to A.M.A.

In a subscription contest, which was to close April 30, a number of Indiana Auxiliaries had obtained special ratings by exceeding their quotas of new subscriptions. The last processed list showed Porter and Perry Counties had placed in the 1954 "Most Exclusive Club". Porter County Auxiliary was credited with 725% of quota; Perry County Auxiliary with 546%. Mrs. E. J. DeGrazia was Porter chairman; Mrs. N. L. Neifert, Perry chairman.

Lawrence County Auxiliary with Mrs. T. J.

Fountaine as chairman, placed in the next highest group with 253% of quota.

Other Indiana counties exceeding their quotas were: Kosciusko County Auxiliary, Mrs. Ryland Roesch, chairman, 144%; Randolph County Auxiliary, Mrs. N. C. Rothermel, chairman, 125%; Floyd County Auxiliary, Mrs. Gerald Wahlfeld, chairman, 179%; and Elkhart County Auxiliary, Mrs. Glenn Patrick, chairman, 155%.

Dr. W. H. Robinson, native of Madison and 1952 graduate of Indiana University School of Medicine, plans to open an office in Mitchell soon. Doctor Robinson was in Mitchell for several weeks following his graduation. He was in the office of Dr. W. B. Strickland. He is an Army Air Corps veteran. He served his internship in Atlanta and has been in practice there.

Dr. James R. Woods, Greenfield, has returned from New Orleans where for the fifth

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consecutive year he attended the annual session of the New Orleans Graduate Medical Assembly.

**Dr. William E. Amy**, who has served as director of the combined Floyd and Harrison County Health Department since 1947, will retire August 1. He has been a health department director for 24 of the 50 years he has been in practice.

**Dr. Joseph A. George**, who has had a part-time office in Edinburgh since November, 1953, was released from the army at Camp Atterbury, March 15, and is now devoting full time to his practice on South Holland Street, Edinburgh.

**Dr. Robert Hill** has joined Drs. Neal Baxter and William Karsell in the clinical practice of general medicine in Bloomington. Doctor Hill is a native of Bloomington and a 1935 graduate of Indiana University School of Medicine. Doctor Hill interned at Indianapolis City Hospital, served a residency in

pathology in Cleveland, then went to the Leahy Clinic in Boston. He served in the Pacific for four years during World War II as an officer in the U. S. Naval Reserve. After discharge from service he became associated with George Washington University, Washington, D. C., where he had been until returning to Bloomington to practice.

**Dr. William Haney**, who recently completed his internship at St. Elizabeth Hospital, Covington, Kentucky, has taken over the office and general practice of Dr. Anna Goss in Madison. Doctor Goss will leave soon for Hartford, Connecticut to take a special course in anesthesia.

Doctor Haney's home is in North Vernon. He is a graduate of Indiana University School of Medicine.

**Dr. Ralph F. Bowman** has joined the staff of Linville Memorial Clinic at Columbia City. He is a graduate of Indiana University School

(Please turn to page 530)



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of Medicine, interned at San Diego County Hospital, California, and served as a battalion surgeon during the Korean war. He was formerly with the Indiana State Board of Health and has been in private practice.

**Dr. William L. Donham** who has been in practice in Bicknell for the last seven years has given up his medical practice and plans to enter a television school. Doctor Donham is an I.U. graduate and served in the army for two years.

**Public medical forums** will again be presented in Evansville in the fall by the Vanderburgh County Medical Society. Decision to continue the programs inaugurated in 1953 was made at a meeting March 30. The society will sponsor the six forums jointly with the Evansville Press. Topics to be discussed will be selected by popular public vote through the newspaper.

### National Guard Has Openings for Doctors

The Indiana National Guard announces that changes in Defense Department regulations allow doctors in any priority of the "Doctor-Draft" classification to obtain commissions in the National Guard and serve in their home communities. The Indiana National Guard has a Class "A" Reserve classification which allows 40 two-hour sessions a year in addition to two weeks' summer encampment. The 38th Division, Indiana National Guard will train again this summer at Lake Margrethe, Michigan, July 18 to August 1.

Openings are available all over the state and particularly in the southern half of the state. Contact the Division Surgeon, 711 North Pennsylvania Street, Indianapolis, Indiana, for details.



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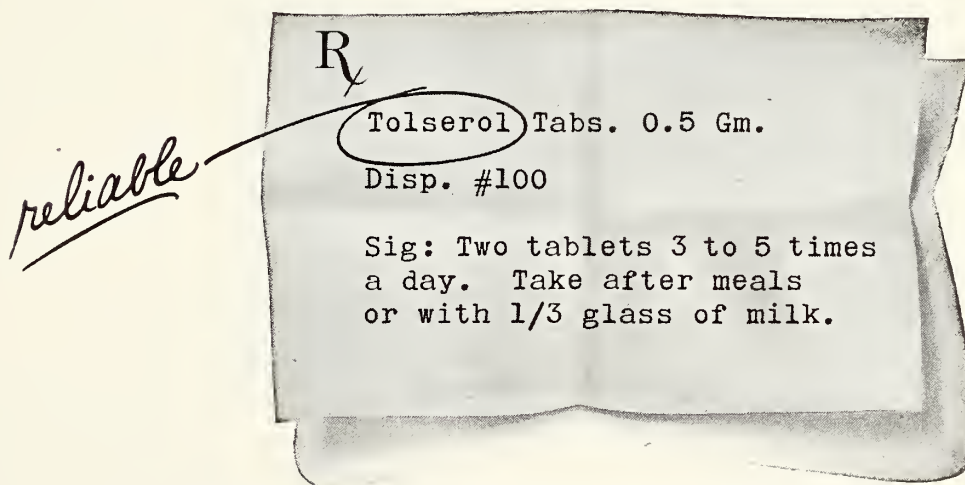
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Dr. William R. Chattin, 1948 graduate of Indiana University School of Medicine, is associated with Dr. George F. Parker, Jr., Indianapolis, in pediatrics practice. He was recently discharged from military service.

The Third International Poliomyelitis Conference will be held in Rome, Italy September 6-10, 1954. Sponsors are the National Founda-

tion for Infantile Paralysis, U.S.A.; the University of Rome, Italy; the High Commissioner of Hygiene and Health, Italy; The National Council of Research, Italy; and the National Foundation for Maternity and Child Care, Italy. Sessions will be held at the Orthopedic Clinic of the University of Rome. Inquiries regarding the conference should be addressed to the Secretariate of the Third International Poliomyelitis Conference, Via Lucullo 6, Rome. Telegraphic address is Inpolio, Rome.

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### Session on Legal Medicine At San Francisco Meeting

A Session on Legal Medicine in the Section on Miscellaneous Topics of the Scientific Assembly will be presented at the American Medical Association meeting in San Francisco in June.

In recognition of the growing importance of the many situations in which medicine may contribute to the clarification of medicolegal situations this informative program has been planned. Six papers will be presented by legal and medical authorities on Thursday morning, June 24, in the Masonic Temple, 25 Var Ness Avenue. Announcement of the session was made by J. W. Holloway, Jr., Secretary. The Committee on Medicolegal Problems, American Medical Association.

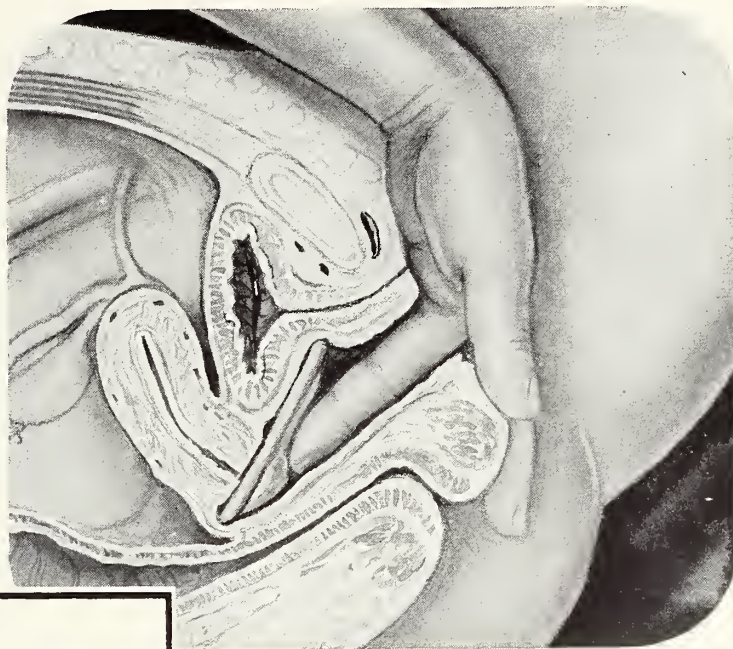
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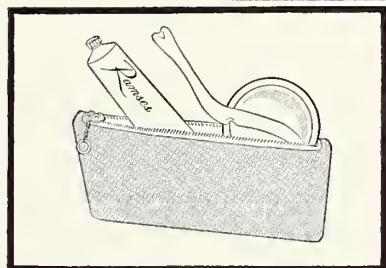
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### Thrombosis and Embolism Conference at Basle

An International Conference on Thrombosis and Embolism will be held from July 20

through July 24 in Basle, Switzerland. The conference was initiated privately by the University Hospital for Women, Basle, because of the increasing importance of thromboembolic diseases and of anticoagulants. It is intended during the conference to discuss the possibility of constituting special sections within the Haematological Societies to cover thrombosis and embolism. Many Swiss medical and public health associations are serving as patrons for the conference.

An impressive list of speakers, all specialists in the field, has been announced. Among the 13 specialists from the United States who will appear on the program is Dr. Nelson W. Barker, Mayo Clinic, who was a guest speaker at the 1953 convention of the Indiana State Medical Association and whose paper "Diagnosis, Prevention and Treatment of Venous Thromboembolic Disease" is published in this issue of THE JOURNAL.

Arrangements to attend the Basle conference may be made through the American Express offices at 20 South Michigan Avenue, Chicago.



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## Views at County Officers Meeting



Groups of interested county society officers are shown as they take notes or sustenance at the 29th Annual Conference of County Medical Society Officers held March 7 in the Indiana University Medical Center's new Student Union building.

At upper right Dr. E. H. Clauser, Muncie, is seen reading the prepared speech of Dr. Walter L. Porttens. Doctor Porttens was unable to attend because of a family death. At Doctor Clauser's left is Dr. Wm. Harry Howard, Hammond, I.S.M.A. president; and Dr. Lester D. Bibler, Indianapolis, counselor.

Center picture, left, shows Robert Hollowell, Indianapolis, legal counselor for I.S.M.A., in conversation with Dr. James L. Doenges, Anderson, Madison County Medical Society president.

# News from the County Societies

Friendship House at Delphi was the meeting place for the **Carroll County Medical Society** February 17 when members and their wives attended a dinner meeting and later heard a tape recording on "Cardiac Arrhythmias".

Dr. James M. McFadden, St. Elizabeth's Hospital, Lafayette, was the guest speaker for the March 17 meeting of the Carroll County Medical Society which was also held in Friendship House, Delphi. After a joint dinner meeting with the Cancer society, the group heard Doctor McFadden discuss, most adequately, the importance of early detection of cancer. A question and answer period followed and a Cancer society film "The Deepening Shadow" was shown.

Six members of **DeKalb County Medical Society** viewed a film on "Rheumatoid Arthritis" at a March 9 meeting in Souder's Hospital, Auburn. The meeting was held at 9 p.m. The next meeting of the group was scheduled for May 11 in Souder's Hospital, Auburn.

Dr. John R. Russell, Indianapolis, presented a paper on "Intercranial Hemorrhage" in which he discussed causes and treatment before 18 members of the **Fayette-Franklin County Medical Society** March 9 in the Connersville Country Club. Discussion and a

business meeting following presentation of the paper.

Robert J. Amick, field secretary of the Indiana State Medical Association, was a guest and spoke briefly on several matters, particularly the ISMA trips planned in connection with the A.M.A. meeting in June.

Thirty-five members of **Grant County Medical Society** met for a 6:30 dinner meeting February 25 in the Moose Lodge in Marion. Dr. Charles Hamilton, South Bend, was the guest speaker, discussing "Anesthetic Complications". The March 25 meeting was "Ladies Night" and was held in the Mecca Club in Marion.

Dr. Carl Porter, Jasonville, discussed "High Blood Pressure" at the March 11 meeting of the **Greene County Medical Society**. The dinner meeting was held in Freeman Greene County Hospital with 11 members present. The April 15 meeting was also to be held at the hospital.

Kenneth W. Bush, I.S.M.A. field secretary for northern Indiana, was the guest speaker at the March 10 meeting of **Jasper-Newton County Medical Society** in the Brook Hotel at Kentland. Seventeen members and guests attended. Mr. Bush told of a new program being promoted by both the I.S.M.A. and

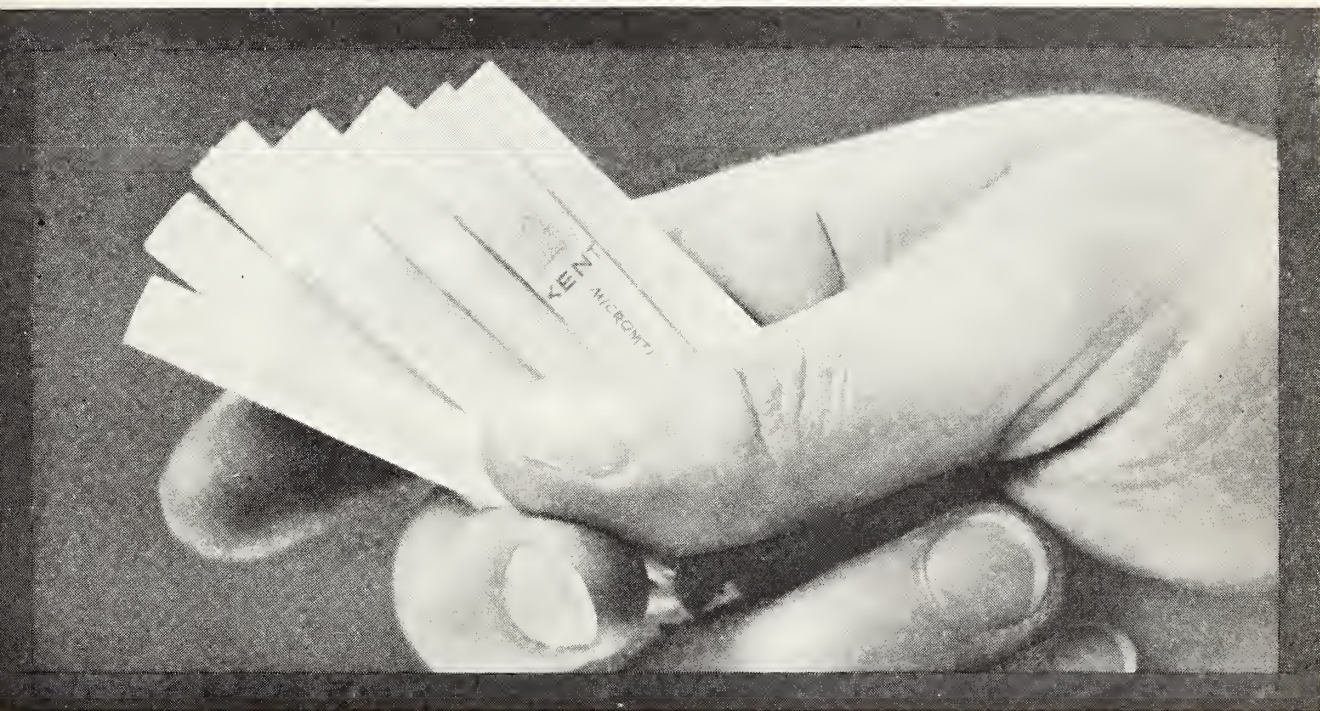
Photographs below were taken at a recent meeting of the **Daviess-Martin County Medical Society** in the Daviess County Hospital, Washington. From left to right are Drs. L. M. McNaughton; Wm. C. Schafer; G. W. Dickinson; H. B. Lindsay, secretary of hospital staff; A. G. Blazey; J. J. Farris and C. P. Fox.





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A.M.A. to create better understanding between doctors and patients. To illustrate he played a recording of a recent public medical forum held in Evansville in which there was unusual interest as indicated by the attendance. Through the new programs, a panel of doctors speaks to a lay group and then answers questions from the audience. Subjects are generally selected by the public, Mr. Bush said.

Members of **Hancock County Medical Society** and their Auxiliary held a dinner meeting March 22 in the Hancock County Hospital when a number of hospital problems were discussed under the leadership of the supervisor of nurses. R. J. Amick, field secretary, discussed several organizational matters.

Guest speaker was Dr. Joseph Haymond who spoke on "Fluid Balance" which he illustrated with a film obtained through Harvard University.

Dr. Robert D. Arnold, Indianapolis, spoke on "Bleeding during Pregnancy" at the

March 9 luncheon meeting of the Hendricks County Medical Society which was held in the OK Restaurant, Danville.

Dr. Lester D. Bibler, Councilor, also spoke, stressing the importance of the preceptorship program which will be started next fall at Indiana University School of Medicine.

Trips planned by ISMA in conjunction with the American Medical Association convention were outlined by R. J. Amick, field secretary.

**Harrison-Crawford County Medical Society** members met April 1 in the Harrison County Hospital, Corydon, for a dinner meeting with eight present. A general business meeting followed with discussion led by Dr. P. M. Davis, New Albany, and R. J. Amick, field secretary for I.S.M.A.

"The Use of Tantalum Mesh in Hernia Repairs" was the title of a paper presented to 24 members of **LaPorte County Medical Society** March 18 at Peacock Fountain Inn,

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Pictured above are Drs. Kenneth O. Neumann, president of Tippecanoe County Medical Society; Ira Cole, Raymond R. Calvert and Joseph W. Strayer, snapped following a society meeting in Lafayette March 9.

Rolling Prairie. The guest speaker was Dr. Chester Guy, surgeon and pathologist at Illinois Central Hospital, Chicago. His talk was illustrated by the use of both slides and colored motion pictures of hernia operations. The pictures were made and shown by Dr. E. C. Olson, chief surgeon at Illinois Central, whose hobby is photography. Members reported the program was outstanding.

The next meeting was scheduled as a joint meeting with Porter County Medical Society on April 15 and was to be held at Beatty Memorial Hospital, Westville.

"Food Allergy" was discussed by Dr. Theon G. Randolph before 30 members of the Montgomery County Medical Society March 18 in the Culver Union Hospital, Crawfords-

ville. Dinner served in the hospital preceded the evening meeting. The April 15 meeting was also scheduled for Culver Hospital.

**Morgan County Medical Society**, members of their Auxiliary and guests met March 28 in the Martinsville Mineral Springs Sanitarium for a dinner and business meeting. The two groups met separately. After a general discussion a wire recording was played. It was "Functional Uterine Bleeding" by Dr.

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Members of Perry County Medical Society, at left, are pictured at their April 6 meeting in Cannelton. Reading from top to bottom and from left to right are Drs. H. S. Dome, D. L. Lashley, P. J. Coultas, N. L. Neifert, L. C. Lohoff, H. S. Dome, D. A. Dukes, N. A. James and H. R. Bush.



W. M. Allen, professor of obstetrics and gynecology, Washington University School of Medicine, St. Louis, and was from the library of I.S.M.A.

Twenty-five members of **Owen-Monroe County Medical Society** held a regular monthly dinner meeting March 25 in the Bloomington Country Club. The guest speaker, Milorad Ilich, gave a graphic account of his war and postwar service and overall picture of the world situation as he sees it. There was a brief business meeting.



A general business meeting and the film "Intra-Articular Injections of Hydrocortisone" comprised the program for the **Putnam County Medical Society** March 12 when 14 members met in the Student Union Building on the DePauw campus, Greencastle.



A threatened epidemic of scalp ringworm, the school roundup and immunization program were topics discussed at the March 10 meeting of the **Shelby County Medical Society** in the W. S. Major Hospital.

Speakers were Dr. Albert L. Marshall, Jr. and James McCloy of the Indiana State Board of Health who spoke on "Communicable Disease Control". Sixteen members were present for the 5:30 to 9 p.m. meeting.

**Wabash County Medical Society** members recently voted to sponsor a series of educational programs to be broadcast over the local high school radio station, WSKS. The transcribed programs were to be broadcast each Monday and Friday morning. Each of the 13 transcriptions, which cover health subjects of





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Wells County doctors, above, are pictured at a recent meeting in Bluffton. Top, Dr. Richard P. Yoder, secretary, and Dr. Homer B. Annis, president. Lower group includes Drs. R. L. Johnston, Jack L. Eisaman, and Doctor Yoder.

general interest to parents of school age children, will be 15 minutes in length.

Warrick County Medical Society held a luncheon meeting in the Boonville Elks Club March 11 with four members in attendance. Officers were elected and a suggestion to consolidate with other county societies was tabled indefinitely. The next meeting was scheduled for December, 1954 in the Boonville Elks Club.

Vanderburgh County Medical Society members heard a discussion of malpractice and the

legal aspects of reportable diseases at their April 13 meeting held in the Hotel McCurdy, Evansville. Following the dinner in the Rose Room, a panel composed of Fred Bamberger, legal counsel for the society, Herman McCray, Evansville attorney with a wide experience in the malpractice field, and Dr. Paul D. Crimm, immediate past president of I.S.M.A., discussed the subject and then joined in a question and answer period and roundtable discussion of the problem.

Dr. Hampar Kelikian, assistant professor of orthopedics at Northwestern University Medical School, Chicago, and professor of orthopedics at Cook County Graduate School, Chicago, was the guest speaker at the April 1 meeting of **Elkhart County Medical Society**. He presented a paper on "Fasciotomy of Stasis Ulcer."

Seventy-five doctors attended this dinner meeting in the Hotel Elkhart, Elkhart.

Kenneth W. Bush, field secretary, was a guest and talked briefly on a number of programs and problems.

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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced, with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Only a limited number of Illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication of THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 10th of the month preceding date of issue.

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## DIABETIC SUMMER CAMP OPENING POSTPONED FOR YEAR

**T**HE INDIANAPOLIS DIABETES ASSOCIATION, Inc., has been forced to cancel its plans for a summer camp for diabetic children in July, 1954 after having completed the staffing of, and plans for equipping Camp James Whitcomb Riley at Bradford Woods. Applications for a full camp had been received.

The Association has been advised by the Riley Memorial Association that unavoidable and totally unexpected delays in construction will make it impossible for the camp to operate this summer.

This is a disappointment not only to the Diabetes Association whose members have given time, effort and funds to the project, but also to the Riley Memorial Association, sponsor and developer of Bradford Woods, which has given

the diabetic camp first consideration in all its planning. Construction has begun and will definitely be completed in the summer of 1954; and Camp James Whitcomb Riley will have its first season June 26 to July 24, 1955. Herbert Montgomery has been engaged as camp director.

The camp's board of directors has arranged with the Fletcher Trust Company to serve as trustee and to hold and manage funds given to the camp. The campaign to raise funds to provide camping periods for underprivileged diabetic children is continuing.

Consideration was given to the possibility of operating the camp this summer with temporary housing. Directors decided on the postponement believing that only first-class, permanent facilities would furnish proper protection for the diabetic children.

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## MEDICAL RESERVISTS TO RECEIVE CREDITS FOR ATTENDING AMA MEETING

Reserve retirement point credits may be earned by Reserve Medical Corps officers on inactive duty who attend the sessions of the Section on Military Medicine during the annual meeting of the American Medical Association, June 23-25, 1954, San Francisco, California, the Department of Defense has announced.

This authorization covers eligible physicians who are Medical Corps officers of the U. S. Army, Navy and Air Force Reserves. Point credits will be awarded eligible Reserve officers on the basis of one for each day of attendance, provided sessions attended total more than two hours.

Scientific presentations for the 3-day assembly of specific interest to civilian practitioners will be discussed by military medical authorities. They include the initial care of the severely wounded, arterial grafts in military surgery, retinal burns produced by atomic flash, a new rapid test for determining antibiotic treatment,

and the medical experiences of physicians who were Communist prisoners in North Korea.

Civilian medical leaders who will participate in the program are Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical), Dr. Louis H. Bauer of New York City, Secretary General of the World Medical Association, and Dr. Stanley Olson, Dean of Baylor University College of Medicine.

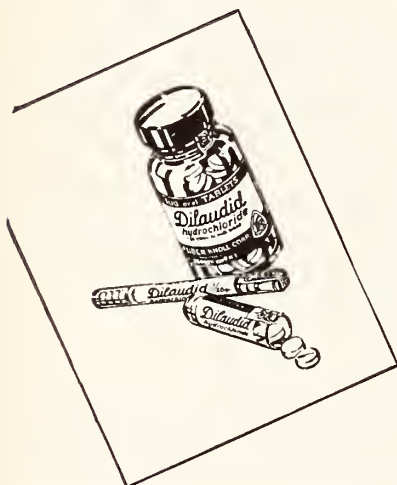
Reserve officers will be required to register for each day's session with their respective service and properly authenticated reports of attendance will be forwarded to the cognizant Reserve reporting unit to assure creditation.

"The meeting provides an excellent opportunity for Reserve officers to earn credit points while being brought up-to-date on developments in the field of medicine", Major General Harry G. Armstrong, Surgeon General of the Air Force and Chairman of the AMA Military Medicine Section, said.

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# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## AGAIN. TO YOUR HEALTH!

Some 15,000 Marion County people took advantage of free tickets to become better acquainted with the accomplishments and aspirations of medical science when they visited the county's first Health Fair at the State Fairgrounds recently.

Screening tests and instructive exhibits gave many people a new appreciation for those devoted to a science which is becoming more exacting with each day's research.

Latest clinical methods were used to examine thousands who requested examinations on blood pressure, hearing, vision and chest X-rays. Lectures by outstanding specialists in treatment of ailing minds and bodies were heard each day during the three-day Health Fair. Audiences were attentive and understanding. Speakers were human and explicit.

Today's busy medical doctor saw at the Health Fair that health is a subject of great interest to the individual. The doctor may possibly have also reaffirmed his knowledge that an unfounded distrust of the medical profession is happily becoming less manifest. The Health Fair is one of many projects responsible. Such an honest exhibition of the doctors' attempt to obtain a friendlier relationship with the public coincides with the opposition of most medical men to professional demagoguery of fraternity, society or association.

The Health and Welfare Council is to be complimented for its efforts in presenting this first Health Fair. Public response indicates it should be made a regular event.

—Indianapolis Star

## HOPE FOR ARTHRITIS

Sir William Osler, whose work at the turn of the century made him one of the most famous physicians of all time, once said: "When I see an arthritic entering the front door, I leave by the

back door." What he meant, of course, was that the medical science of his day could do virtually nothing for those who suffered from arthritis. And the ailment still stubbornly resists man's efforts to conquer it.

The more than 10,000,000 arthritics in the country are ample proof that it cannot be prevented—and doctors are reluctant to speak of cures when their treatments cause the symptoms to disappear for a time only to reappear later.

Nevertheless, progress has been made during the last several decades. Today the specialist can say, at least, that cure may be possible, that people can be taught how to avoid arthritis and how to relieve the pain, and that their patients' chances of living a long and useful life are excellent.

Much has been learned and knowledge is being used with good effects against this disease that can cripple and can shorten life. One problem is how to spread this knowledge among laymen, so that patients can co-operate with the medical profession. Knowledge is a good weapon against disease in general and an especially potent one against arthritis.

—Terre Haute Star

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## MEDICAL EDUCATION AND HOSPITALS COMMITTEE REPORTS ON CONFERENCE

The following report has been made by the Committee on Medical Education and Hospitals of the Indiana State Medical Association following the recent meeting in Chicago of the state chairmen of the American Medical Education Foundation. Dr. John A. Shively, Bluffton, represented the committee at the conference.

Medical schools will continue to require financial assistance in order to maintain their high standard of medical education, Louis H. Bauer, M.D., President of the American Medical Education Foundation, recently stated in a meeting of the state chairmen of this Foundation in Chicago. The medical profession raised more than a million dollars for the Foundation in 1953, and a goal of two million dollars is being set for 1954. The American Medical Association will again contribute \$500,000, but the remainder must come from individual members of the medical profession through their contributions to this fund. In 1953 industry and the nation's corporations gave over \$1,300,000 to the National

Fund for Medical Education, and if the medical profession can increase its contributions, it is hoped that industry will in turn increase its contribution.

An additional source of income will come from the Audio-Digest Foundation, a non-profit subsidiary of the California Medical Association which distributes tape recorded abstracts from current literature as well as tape recordings of medical lectures and panel discussions. Reserve funds accruing from the distribution of these tapes will be contributed to the American Medical Education Foundation.

Woman's Auxiliaries contributed over \$34,000 to the A.M.E.F. in 1953 and Mrs. Frank Gastineau, Indianapolis, Chairman of the A.M.E.F. Committee of the Woman's Auxiliary to the American Medical Association presented "In Memoriam" cards for contributions to the A.M.E.F. and discussed their use in lieu of flowers in memory of a friend, relative, or patient.

Hiram W. Jones, executive secretary of the American Medical Education Foundation, stated that there has been a yearly increase of the number of contributors to the Foundation. Two states, Illinois and Utah, have assessed each of their members for a contribution, while New York adds a given amount to the State Society dues with this contribution being voluntary. These plans have helped solve the problem of annual solicitation and are to be considered in those states having a heavy physician population.

Indiana set \$50,000 as its goal in its contribution to the American Medical Education Foundation in 1953 and collected \$37,000 during the year. This placed Indiana as the fourth largest contributor to the Foundation for the past year. Those funds designated for Indiana University School of Medicine as well as the grants given to the University by the Foundation from the National Fund continue to be given to the Indiana State Medical Education Foundation Trust. It is hoped that the members of the Indiana State Medical Association will continue their support of the fight to save our medical schools from federal subsidy and regulations by giving generously to the American Medical Education Foundation in 1954.

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### Auxiliary Announces San Francisco Program

The Woman's Auxiliary to the American Medical Association will have headquarters in the Hotel Fairmont, San Francisco, during the Thirty-first Annual Meeting of the organization June 21-25.

Mrs. Harry C. Harvey, Fort Wayne, president of the Woman's Auxiliary to Indiana State Medical Association, said that the co-chairmen in charge of convention arrangements for the Auxiliary are Mrs. Matthew N. Hosmer and Mrs. Edmund J. Morrissey. A cordial invitation is issued to all Auxiliary members, their guests and the guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general meetings of the Auxiliary.

Registration starts Sunday noon on the lobby floor of the Hotel Fairmont.

### Inter-Society Cytology Council to Meet in Boston

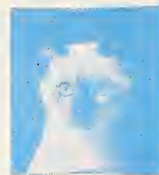
The second annual meeting of the Inter-Society Cytology Council will be held in Boston, November 12 and 13, 1954.

Those having papers to present are invited to submit three copies of the title and an informative abstract of not more than 200 words to Dr. John B. Graham, Chairman of the Program Committee, 32 Fruit Street, Boston, Massachusetts, before July 15. Abstracts of all papers accepted will be published in the official program.

Papers will be limited to 15 minutes and will be discussed in related groups rather than individually. A maximum of eight papers will be presented to each session.

Particular attention is suggested for the endometrium and lesions of the gastrointestinal tract. No further verification is indicated in cancer of the cervix and the lung.

For additional information contact the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Boulevard, St. Louis, Missouri.



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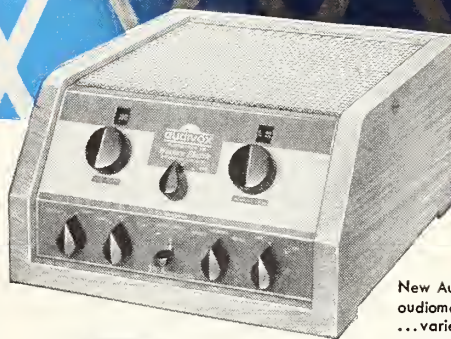
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# Wanted: PHYSICIANS LOCATIONS

As part of the Physician Placement Service of the Indiana State Medical Association, through which an effort is made to bring together the physicians interested in a new or initial location and the communities needing doctors, this list of inquiries received during April has been compiled and is published in THE JOURNAL. The lists are also sent to the sponsor in each community which is seeking a doctor.

A friendly invitation to the young doctors who wish to establish practice has, in many cases, led to a satisfactory solution for both parties.

Locations where doctors are needed include:

MULBERRY—Clinton county; population 860.

Contact Mrs. J. A. Kent, Mulberry, Indiana

DANVILLE—Hendricks county; population 2,100. Contact Dr. Paul W. Elliott, Danville, Indiana

ANDREWS—Huntington county; population 1,000. Contact Mr. Robert W. Deal, 233 North Main Street, Andrews, Indiana.

WARREN—Huntington county; population 1,400. Contact Mr. Randolph Fluhrer, Warren, Indiana

SUMMITVILLE—Madison county; population 1,000. Contact Mr. Frank M. Hundley, Summitville, Indiana

NEW BETHEL (Wanamaker)—Marion county; population 400. Contact Mr. Harold Springer, Wanamaker, Indiana

MOROCCO—Newton county; population 1,200. Contact Dr. G. D. Larrison, Morocco, Indiana

RISING SUN—Ohio county; population 1,550. Contact Dr. Charles N. Manley, Rising Sun, Indiana

NEW HARMONY—Posey county; population 1,400. Contact Mr. Fritz Long, New Harmony, Indiana

PLYMOUTH—Marshall county; population 5,700. Contact Mrs. P. R. Irey, Plymouth, Indiana

SCOTTSBURG—Scott county, population 2,200. Contact Dr. Marvin L. McClain, Scottsburg, Indiana

EATON—Delaware county; population 1,500.

Contact Richard Ko, M.D., or Mr. Ralph Butterfield, Eaton Canning Company, Eaton, Indiana.

ELLETTSVILLE—Monroe county; population 900. Contact Mrs. C. B. Hall, Ellettsville, Indiana.

CEDAR LAKE—Lake county; population 10,000. Doctor leaving for service August 1 wants two young doctors to carry on and continue in group practice on his return. Modern \$70,000 office building, air-conditioned, fully equipped. Draws practice from rural, industrial and resort area. Contact R. W. King, M.D., Cedar Lake, Indiana.

Doctors who have inquired about Indiana locations during the last month include:

David J. Steigmeyer, M.D. (general practice), U. S. Army Hospital, Fort Riley, Kansas.

R. R. Fabringer, M.D. (general practice or industrial), 241½ E. 10th Street, Erie, Penn.

John J. Devitt, Jr., M.D. (general practice), 521½ Indian Terrace, Rockford, Illinois.

M. M. Camardese, M.D. (general practice), The Children's Hospital, Akron 8, Ohio.

Alvin Bridges, M.D. (general practice), 520 Hartford Street, Dayton, Ohio.

Roger F. Eakins, M.D. (general practice), 1257 S. Jefferson Ave., Saginaw, Michigan.

George A. Swendiman, Jr., M.D. (general surgery or associate in surgery), 1149 4th Avenue, Corning, California.

Charles A. DeKovessey, M.D. (urology), Heur-elton, New York.

Lester I. Nienhuis, M.D. (general surgery), 3207 Groveland Avenue, Houston 19, Texas.

Theodore Bacharacj, M.D. (internal medicine), 2154 1 ASU USAH, Fort Lee, Virginia.

Irvin H. Blumfield, M.D. (ob-gyn), 5532 S. Shore Drive, Chicago, Illinois.

Robert Fincher, M.D. (neuro-psychiatry), Reynolda Road, R.F.D. 1, Winston-Salem, North Carolina.

Richard F. Auler, M.D. (general, institutional or industrial), Winfield Hospital, Winfield, Illinois.



Lauro R. Montemayor, M.D. (general practice), Eastern Illinois State College, Charleston, Illinois.

Keith M. Coverdale, M.D. (pediatrics), Children's Hospital, 226 East Chestnut St., Louisville 2, Kentucky.

Craig R. Sigman, Major (MC) (general practice), 520th USAF Infirmary, Truax AFB, Madison, Wisconsin.

Paul V. Chivington, Jr., M.D. (dermatology), 3794 Mayfield Road, Cleveland Heights 21, Ohio.

Glen L. Swihart, M.D. (general practice), P. O. Box 792, Bradenton Beach, Florida.

Winslow G. Fox, M.D. (group practice with special attention to pediatrics and obstetrics), 136 Carrol Drive, Walker Village, Killeen, Texas.

James P. Elkins, M.D. (ob-gyn), Tripler Army Hospital, APO 438, c/o PM, San Francisco, Calif.

Wilfred L. Thabault, M.D. (ob-gyn), 6022nd USAF Hospital, APO 994, c/o Postmaster, San Francisco, Calif.

William E. Cochran, M.D. (general practice), 272 N. Craig Street, Pittsburgh 13, Pa.

James Weygandt, M.D. (general practice), 611 N. 89th Street, Milwaukee 13, Wisconsin.

Joseph A. Sanacore, M.D. (ophthalmology), 297 Graham Avenue, Brooklyn 11, New York.

Victor E. Bolton, M.D. (ob-gyn), Charity Hospital, New Orleans, La.

Max Singer, M.D. (ophthalmology), 8 East 79th Street, New York, N. Y.

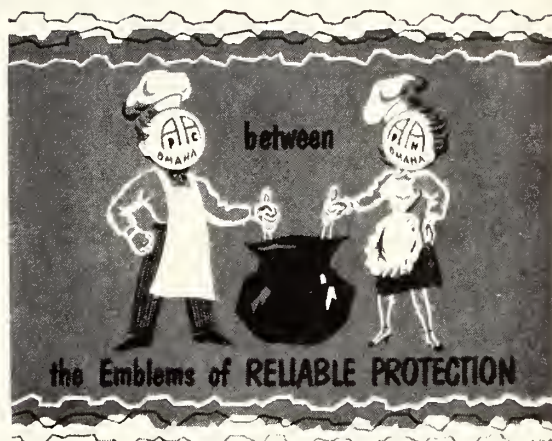
Ned B. Chase, Jr., (general practice), 127 A Palo Blanca Drive, San Benito, Texas.

Andrew J. Bacevich, (general practice), Tripler Army Hospital, APO 438, c/o Postmaster, San Francisco, Calif.

Harold L. Brenton, M.D. (internal medicine with group, partnership or clinic), State University of Iowa Hospitals, Iowa City, Iowa.

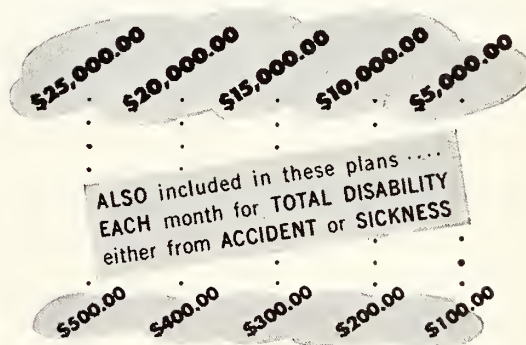
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## I. U. Medical Center Activities

Seventh annual Alumni Day of the Indiana University School of Medicine on May 12 brought 432 physicians and guests from all parts of the country back to the Medical Center campus in Indianapolis for their annual reunion. This was a record registration.

Registration for alumni and guests was in Hurty Hall, Laboratory Science Building, with the official program starting at 10 o'clock.

Guest speakers for the afternoon program included Robert A. Moore, M.D., Vice Chancellor-Elect of the Schools of the Health Professions, University of Pittsburgh, who spoke on "Some Basic Problems in Medical Education"; Frank G. Dickinson, Ph.D., director, Bureau of Medical Economic Research, American Medical Association, whose topic was "Some Current Problems in Medical Economics"; and John D. VanNuys, M.D., Dean, Indiana University School of Medicine who gave a "Report on the Medical Center" outlining the status of the new Medical Science Building, remodeling of Riley hospital and possible remodeling of some of the Clinical Building.

Clinics, arranged by advance registration, were held in medicine, surgery, pediatrics, obstetrics and gynecology in the morning; there was open house at the new Student Union building with free swimming for everyone; informal reunions were held and at 11 o'clock there were guided tours of the Student Union Building, Riley Hospital, and the X-ray department.

The traditional fried chicken and strawberry shortcake picnic lunch was held under a big tent. Special seating had been arranged for classes ending in '4' and '9' and class pictures were taken of those groups.

At 2 o'clock, Dr. James O. Ritchey, Indianapolis, president of the Alumni organization for 1953-54, presided at the business meeting in



Dr. Dickinson



Dr. Moore

the Medical School auditorium. Reports of officers and committees were made following which Dr. Harry P. Ross, Richmond, this year's vice-president, installed the 1954-55 officers. New officers are: President, Dr. Wemple Dodds, Crawfordsville; Dr. Maurice Glock, Fort Wayne, vice-president; secretary, Dr. Olga Bonke Booher, Indianapolis; treasurer, Dr. Donald J. White, Indianapolis; and historian, Dr. Frank Forry, Indianapolis. The last three officers were reelected.

The following nominations were made for officers for 1955-56:

President, Dr. Norman R. Booher, Indianapolis; vice-president, Dr. Donald Grillo, South Bend; secretary, Dr. Olga Bonke Booher, Indianapolis; treasurer, Dr. Donald J. White, Indianapolis; historian, Dr. Frank Forry, Indianapolis.

Councilors elected to serve in 1955-56 are Drs. Hugh Ramsey, Bloomington; Seth Ellis, Anderson; Roy Lee Smith and William Dugan, both of Indianapolis.

Special activities were planned for wives and guests throughout the day. The Roof Lounge of the Student Union Building was reserved for use by the women. A coffee hour was held at 10;

(Please turn to Page 582)

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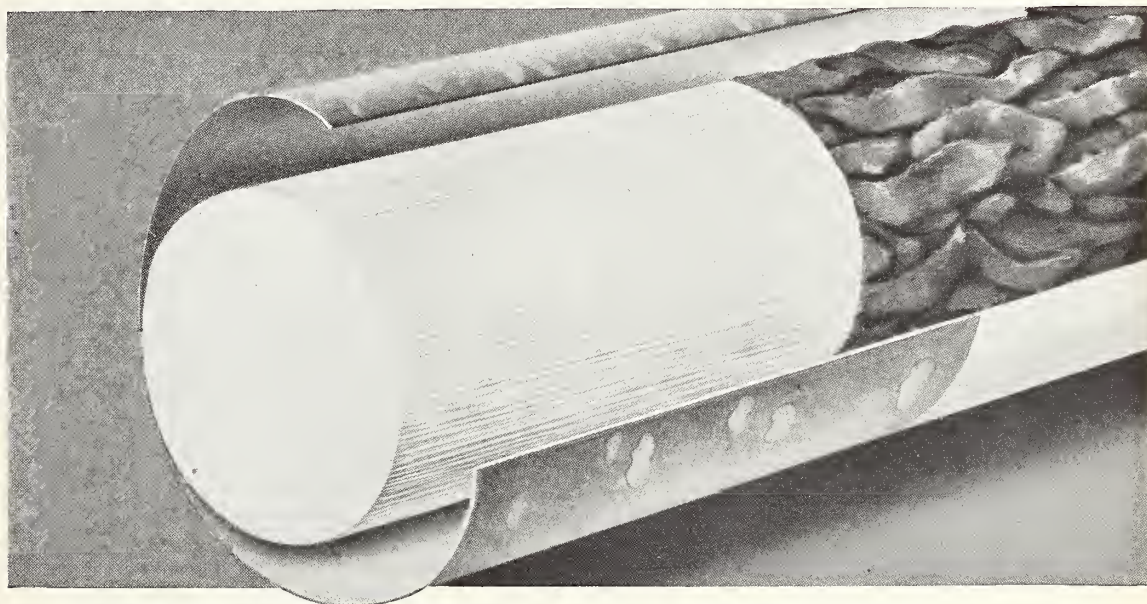
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## I.U. Activities

(Continued from Page 580)

card tables were set up and the swimming pool was open; guided tours were arranged for 11 and 2 o'clock; and at 3 p.m. the women guests were entertained at a "Water Show" by I. U. swimming and diving teams. They joined the doctors for the noontime picnic.

Dr. Emile Frederic Holman, professor and chairman of the Department of Surgery, Stanford University, spent the week of May 10 as a George A. Ball Visiting Professor in Surgery at the Indiana University School of Medicine. Doctor Holman participated in a series of ward rounds, clinics and surgical programs with students and staff of the Medical Center hospitals during the week and on May 11 addressed members of Indianapolis Medical Society.

Previous holders of the Visiting Professorship this spring have been Dr. I. S. Ravdin, professor and chairman of the Department of Surgery, University of Pennsylvania; and Dr. Philip Sandblom, professor and chairman Department of Surgery, University of Lund, Sweden.

The Visiting Professorship was established in November 1952 by the Riley Memorial Association and the I. U. School of Medicine honoring George A. Ball, Muncie industrialist, for his long association with Riley hospital and the Medical Center.

Dr. M. Edward Davis, Joseph Bolivar DeLee Professor of Obstetrics and Gynecology and department chairman, University of Chicago, was the guest speaker for the postgraduate course

in Obstetrics and Gynecology at the Indiana University School of Medicine, April 28-29. The course, "A Resume of Recent Developments," is presented by members of the staff.

Specialists in ear, nose and throat diseases from a half-dozen states were enrolled for the 34th annual anatomical and clinical course in Otorhinolaryngology at the Indiana University School of Medicine, April 5-19. The course, presented by members of the staff, originated in 1920 and has been held each year since.

Three hundred delegates to the 10th national convention of Alpha Epsilon Delta, premedical honor society, joined with premedical students from Indiana colleges and universities, for a tour of the Indiana University School of Medicine and the Medical Center campus.

Fifth annual Burton D. Myers Lecture, sponsored by the Indiana University School of Medicine chapter of Nu Sigma Nu, was presented by Dr. Lester Dragstedt, Chairman and Professor of Surgery, University of Chicago. The lecture-ship honors the late Dr. Myers, one of the first members of the Medical School faculty and dean of the Bloomington division for many years.

Among recent guests on the campus was Dr. V. S. Von Euler, professor of Physiology, Karolinska Institute, Stockholm. Dr. Von Euler spoke at the I. U. Medical School seminar, discussing, "Sympathoadrenal Factors in Stress."

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Approximately three hundred Hoosier physicians registered for the Medical School's annual Symposium on Malignancy, in April, when cancer of the lung was discussed by Dr. L. L. Robbins, Harvard; Dr. R. J. Anderson, U. S. Public Health Service; Dr. N. Chandler Foot, Cornell; Dr. Evarts Graham, Washington University; Dr. David Karnofsky, Cornell; Dr. Herbert C. Maier, Columbia; Dr. John H. Gibbon, Jr., Jefferson; and Dr. George Wright, St. Luke's Hospital, Cleveland.





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1. Thorn, G. W., et al., *New England J. Med.* 248:632, April 9, 1953.

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Final selection of the 150 senior medical students for internships in Army Hospitals has been announced by Major General Silas B. Hayes, Acting Surgeon General of the Army.

Representing 49 American, 1 Canadian and 1 Puerto Rican medical schools, the students will be commissioned upon graduation and on July 1 will be called into active duty as first lieutenants in the Medical Corps of the United States Army Reserve. On completion of 12 months duty they may choose to remain in the Army or return to civilian life unless their "Doctor Draft" law obligations interfere.

Indiana men selected include Charles R. Gumper, Elkhart (University of Indiana), Tripler Army Hospital, Hawaii; Lawrence F. Misanik, East Chicago (Loyola University), Valley Forge Army Hospital, Pennsylvania; and Hugh A. Stallings, Rockport (University of Indiana), Wm. Beaumont Army Hospital, Texas.



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1. Heller, E. M.: The Treatment of Essential  
Hypertension. *Canad. Med. Assn.  
Jour.*, 61:293, Sept., 1949.

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The Seventh Annual meeting of the American Association of Blood Banks will be held in the Shoreham Hotel, Washington, D. C., on September 13, 14, and 15. An announcement from the office of the Secretary, American Association of Blood Banks, 3500 Gaston Avenue, Dallas, Texas, says an excellent scientific program, interesting exhibits, a special course for technologists and roundtable and panel discussions led by national and international authorities have been included on the program.

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11 inclusive at the Hotel Statler, Washington, D. C. All sessions will be open to members of the medical profession in good standing with the American Medical Association. Details may be obtained from the Executive Offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

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Volume 47 — June 1954 — Number 6

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## PRESENT-DAY SURGERY OF THE HEART AND GREAT VESSELS\*

JOHN V. THOMPSON, M.D., and  
EDWIN R. EATON, M.D.

*Indianapolis*

THE PURPOSE OF THIS PAPER is to present the various cardiac conditions which at the present time appear to be amenable to surgery. Some of the major diagnostic criteria and pathologic physiology are discussed in the paper. A brief description of the operative procedures is given together with the limitations of such therapy. It must be remembered that this field is rapidly advancing and changing, and what is true today may not be true tomorrow in some instances. Emphasis is placed on points of considerable interest and this discussion is not intended to be all-inclusive in scope.

Among the more recent diagnostic methods, which may be of particular aid, are angio-cardiography<sup>1</sup> and cardiac catheterization.<sup>2, 3, 4</sup> The heart and great vessels may be visualized by the injection of contrast media through a suitable artery or vein. The size of the various chambers

of the heart may be confirmed. Dilatations or constrictions of the heart and great vessels may be outlined and some abnormal communications demonstrated on serial roentgenograms. The exploring catheter visualized by the fluoroscope may discover abnormalities. The degree of oxygen saturation in the chambers of the right heart and pulmonary artery as well as the pressures in these locations, may be determined by catheterization. The results of gas analysis of the peripheral arterial blood and the determination of the rate of oxygen consumption together with the above data, when applied in a mathematical formula, may denote abnormal communications between the right and left sides of the heart and their tributaries. The volume of blood shunting and of blood flow in the systemic and pulmonary circuits may be calculated by this means. Pressure studies may reveal the effects of cardiac malformations upon the dynamics of the circulation. These studies have been of great value in adding to our knowledge of certain conditions. The diagnosis, however, is mainly dependent

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\* An extensive bibliography is attached to the reprints for the benefit of the practitioner who desires a more detailed reference. The original bibliography will be on file in THE JOURNAL office.



upon the usual clinical methods with great reliance being placed upon fluoroscopy to study the various chambers of the heart and great vessels.

### ACQUIRED CONDITIONS

**MITRAL STENOSIS:** The major cause of mitral stenosis is rheumatic fever, though in rare instances the condition may be congenital in origin. An increasing degree of obstruction to the circulation results in enlargement of the left atrium and hypertension in the pulmonary circuit. Later, right ventricular enlargement occurs and usually decompensation. The stages of the disease may be classified as: (1) asymptomatic, (2) early symptomatic, (3) progressively decompensated but reversible, and (4) irreversibly decompensated. Group 4 offers very little hope of surgical improvement, inasmuch as the cardiac muscle is irreparably damaged and is rarely able to recover much of its function. The younger patients in Group 1 deserve careful consideration for surgery because their future is quite unpredictable at this time. The greatest opportunity for surgical endeavor exists in Groups 2 and 3. Surgery is contraindicated by the presence of rheumatic activity, subacute bacterial endocarditis, gallop rhythm, and the usual systemic factors. Operative intervention is seldom feasible by the fifth decade.<sup>5</sup> Surgery is indicated only when mitral stenosis is the significant factor in the abnormal circulatory dynamics. The presence of multivalvular disease other than a minimally associated mitral insufficiency, aortic valve lesion and accompanying left ventricular enlargement is a contraindication to surgery. A left axis deviation is never acceptable. The murmur of mitral stenosis is a late diastolic-presystolic rumble. The presence of a significant systolic murmur or an early diastolic murmur is suggestive of mitral insufficiency or aortic lesions, depending on the location. Auricular fibrillation does not prevent surgery if the ventricular response to medication is good. Previous embolization may be an indication for surgery, and mural thrombi in the appendage may be controlled by ligation of the structure.<sup>6, 7</sup>

The operative procedure<sup>8</sup> consists of the insertion of a finger into the purse-stringed left auricular appendage and separation of the valve leaflets in the commissures by the finger fracture method of Harken<sup>9, 10</sup> or by the use of the Bailey<sup>11, 12</sup> knife. The attack is directed principally at the anterior commissure due to the dan-

ger of tearing into the outflow tract of the aorta from the posterior commissure. The softer, more pliable valves are more easily separated by the finger and offer the best prognosis. The more fibrosed or calcified orifice may necessitate the use of the knife in the commissure. Prevention of embolization is attempted by occlusion of the arterial supply to the head at critical points during the operation.<sup>13</sup> Hemorrhage, arrhythmias, arrest, and anoxia are all possible complications as in any cardiac surgery. Creation of too large an orifice will result in mitral regurgitation. Several hundred patients have now been operated upon in this country with a mortality rate of five to ten percent.<sup>14</sup> Seventy-five percent of the patients subjected to surgery have been improved.

**MITRAL INSUFFICIENCY:** Mitral insufficiency may be caused by rheumatic infection, trauma during mitral commissurotomy, or may be the result of certain congenital abnormalities. This condition is characterized by regurgitation of a portion of the left ventricular content into the left atrium with dilatation of the left atrium and enlargement of the left ventricle. This phenomenon is manifested by a systolic murmur at the apex of the heart.

Mitral insufficiency may be aided by commissurotomy when regurgitation is a very minor part of the picture of mitral stenosis. When regurgitation is the greater part of the picture or is as severe a factor as the stenosis, other methods of therapy must be considered, providing there is no irreversible decompensation. The limitations of such surgical procedures have not been clearly outlined as yet. The experimental use of various plastic devices and grafts has been described in the literature. These have been used both to create a ball-valve effect over the mitral orifice and to narrow the atrio-ventricular ring about the valve. Bailey<sup>15</sup> has devised a method which appears to offer considerable promise, utilizing pericardial strips or vein grafts. Guided by a finger in the left auricular appendage these are threaded by a suture passed from the left ventricular wall up through the valve leaflet to the left auricle and back, thus surrounding the commissure. The material is then tied around part of the valve opening and secured to the cardiac wall to narrow the orifice. He has performed nearly 100 operations by this method with a considerable rate of improvement. Bailey has recently modified his technique by introducing a suture along



the finger inserted through the appendage with the aid of a new suturing instrument.

It should be noted in connection with mitral valve surgery that a great deal of information can be obtained by the palpating finger.<sup>16</sup> A marked late diastolic thrill is felt over the apex of the left ventricle in mitral stenosis, whereas in regurgitation a systolic thrill is palpated over the left auricle and pulsation may occur in the left auricle. The intra-cardiac finger may further note a regurgitating jet at the orifice of the mitral valve with the occurrence of insufficiency.

**AORTIC STENOSIS:** Rheumatic fever and arteriosclerosis are the usual causes of the stenosis. The obstruction in the outflow tract of the left ventricle results in a lower and more sustained systolic blood pressure and a small pulse pressure differential. The left ventricle becomes markedly hypertrophied and the demand upon the coronary flow is thus greater than usual, which may be manifested by pain. A marked systolic murmur and thrill are noted over the aortic area. The aortic second sound is absent in acquired stenosis, but is usually present in congenital subaortic stenosis. The valve cusps may be fused along their commissures or there may be a fibrotic retraction of the leaflets with calcific thickening about the orifice which predisposes toward regurgitation. A significant degree of aortic regurgitation is marked by an increased pulse pressure and a diastolic murmur over this region. Significant insufficiency would appear to contraindicate surgery, since the regurgitation may be increased by surgical intervention under the present methods. The ventricle is unable to dilate in order to increase the stroke output and the coronary circulation in turn suffers a decreased blood supply. Decompensation of any significant degree at the present time prevents surgery, inasmuch as the highly damaged hypertrophied left ventricle is unable to recover its function. Gallop rhythm, rheumatic fever and subacute bacterial endocarditis are other contraindications to surgery.<sup>17</sup>

Various approaches to this problem have been made in the past, such as the use of plastic valves, direct division of the stenosis from above or below, attempted replacement of the valves and by-passing of the obstruction.<sup>18, 19</sup> None of these methods have been particularly successful to date. Bailey, Glover and O'Neill<sup>20, 21</sup> have

dilated the stenosed aortic valve under the above criteria with reasonable success. A dilating instrument is introduced through the left ventricle and guided by a wire into the aortic valve, where it is opened to dilate the orifice in the region of its commissures. Bailey now prefers to approach the valve by a finger and the instrument inserted through a double pouch attached to the aortic wall. Dilatation of too marked a degree is to be avoided because of the possibility of producing regurgitation with the above-mentioned results. A number of such operations have been successfully performed over the country with a mortality rate in the region of 15 percent.

Where there is a coexistent aortic and mitral stenosis of operable degree, apparently both should be attacked at the same operation. The aortic commissurotomy should be done first where an apparent significant degree of mitral insufficiency exists.

**AORTIC INSUFFICIENCY:** Attempts at the surgical treatment of aortic insufficiency to date have not met with a great deal of success. The methods have been mainly those of narrowing the aortic orifice, the substitution of grafts or the fashioning of artificial valves of various sorts in an effort to reduce the amount of regurgitation.

**CONSTRICTIVE PERICARDITIS:** The majority of such cases are caused by tuberculosis although the constrictive process may be due to other inflammatory and traumatic etiologic agents. The incidence has been markedly decreased with the use of anti-microbial therapy in tuberculosis. The major difficulty in this entity is that a marked encasement of the heart prevents adequate filling of this structure with a resultant increase in venous pressure. The diagnosis is based on the history of pericardial effusion, the presence of edema, enlarged liver, a quiet heart, evidence of calcification of the pericardium and an inversion of the T wave. The surgical problem is the removal of this membrane. Relief may be dramatic in a very edematous patient with large vessels in the neck and apparently in very poor clinical condition. It was believed at one time that surgery was contraindicated until any tuberculous process had been brought under complete control. It is now the opinion that, with the use of anti-microbial therapy in this disease, operative intervention may be carried out

much earlier and even when a residual pericardial effusion still exists,<sup>22, 23, 24</sup>

Where the membrane is firm it is necessary to establish a plane of cleavage between the "peel" and the epicardium and to remove all outer tissue including the pericardium. The great veins at the base of the heart must be freed in some instances to allow filling of the heart.<sup>25</sup> It may not be necessary to remove early granulation tissue of a tuberculous nature which may be reversible under antimicrobial therapy. The best exposure of the heart is obtained by a left antero-lateral incision to which may be added a median sternotomy. Care must be taken not to injure the coronary vessels. The results are usually good.

**PERICARDIAL EMPYEMA:** This condition is best approached by paracentesis with aspiration, irrigation and the instillation of antimicrobial drugs. If the purulent material becomes thickened despite the use of these procedures and use of the new enzymatic agents, surgical drainage is indicated by means of a costal-chondral resection.<sup>26, 27</sup>

**TUMORS AND CYSTS OF THE HEART:** Pericardial cysts are manifested as well-defined round densities usually located in the right mediastinum.<sup>28</sup> They may or may not move with pulsation. These cysts contain a rather clear fluid and can be removed readily in most instances. Many of the tumors involving the heart and pericardium are metastatic and are inoperable for the most part. Some primary tumors of the outer aspect of the heart and pericardium are of a benign nature and can be excised with repair of the defect. Even malignant tumors of the myocardium which may be enormous can be partially removed for palliative relief. These are usually of the sarcomatous variety. Intra-cardiac tumors of a benign nature, such as fibromas and myomas, have been removed with success.<sup>29</sup> Manipulation by the finger inserted through the atrial appendage aids in the management of such tumors. A diagnosis of these rare tumors can be made by angio-cardiography in some instances. Surgical possibilities in this field should be considerably extended with the advent of extra-corporeal circulation devices.<sup>30</sup> Unfortunately, these machines are not as yet perfect or practical.

**PERFORATION OF THE HEART:** Perforation of

the heart should be suspected whenever there is a wound above the level of the diaphragm which is medial to the left mid-clavicular line or the right peristernal line, particularly if the path is medial. Likewise, it is to be remembered that devious pathways may be taken by a missile toward the heart from any direction. Portions of the bony chest wall may compress or perforate this organ. Pressure should be relieved so that the heart may fill and maintain output. Perforation either of the heart or of the great vessels within the pericardial sac will give the same picture. Perforation of the vessels outside the heart presents the picture of hemothorax or mediastinal compression and is another subject. Shock and signs of cardiac tamponade such as distention of the vessels of the neck and the disappearance of the cardiac sounds are usually noted when the heart is perforated. The cardiac shadow is widened on the roentgenogram in the presence of significant intrapericardial hemorrhage or effusion.

Anti-shock measures should be instituted at once, though surgery is not to be delayed in attempts to bring the patient out of shock. Tamponade probably should not be relieved by aspiration unless the patient nears the point of death. Frequently the tamponade tends to close the myocardial wound and temporarily prevents further bleeding.<sup>31</sup> The approach is through the fourth left interspace. Division of the costal cartilages is necessary for wide exposure. The pericardium is evacuated and the wound in the myocardium is sutured deeply with mattress and interrupted sutures. The loss of blood is replaced as soon as possible. Most injuries to the major vessels can be sutured with the usual vessel technique.<sup>32</sup> Many patients can be saved by prompt surgical intervention. The Harlem Hospital now has a series of approximately 100 such cases.<sup>33</sup>

**FOREIGN BODIES IN THE HEART AND PERICARDIUM:** These probably should be removed when they are of significant size and there is a possibility of migration or motion. Removal is indicated in these circumstances to reduce the tendency to embolism, thrombosis, infection, pericardial effusion, and damage to the myocardium. The indication is further increased by the presence of symptoms.<sup>34, 35, 36</sup>

When the foreign body is within the heart, an instrument can be passed through the wall with



a purse-string suture in the myocardium for control of hemorrhage. Manipulation may be aided by a finger inserted through the appropriate auricular appendage as in the mitral technique.

**ANEURYSM:** Aneurysms of the thoracic aorta and its major branches near the heart may be caused by syphilis, arteriosclerosis and trauma. Localization of the pathology is tremendously aided by fluoroscopy, the differential blood pressures in the extremities, the presence or absence of pulse, and by palpation of the pulsatile mass where possible. Auscultation will often reveal a murmur. The history and the use of angiocardiology are of exceptional aid in the diagnosis. Aneurysm of the ascending aorta at its origin may cause considerable dilatation of the ventricular outflow tract with aortic valvular regurgitation and left ventricular enlargement. Repair is usually out of the question when irreversible cardiac decompensation is present.

The older methods of management such as the insertion of wire through a cannula into a sacular aneurysm may still have a place but are rapidly falling into disuse. Methods of present-day use consist of the injection of dicetyl phosphate around the wall of the aneurysm or wrapping of the presenting structure with polythene coated with this material.<sup>37, 38, 39</sup> This is done with the hope of producing fibrosis in order to prevent further expansion of the aneurysm or its perforation. A combination of the two methods may be utilized. This therapy is particularly applicable to cylindrical aneurysms and saccular aneurysms with a broad base. Aneurysms with a small eccentric base may occasionally be excised and the artery repaired.<sup>40</sup> Traumatic aneurysms are frequently of this type. The possibility of traumatic aneurysms should be kept in mind at the time of accidents and patients observed for the possible development of this complication. Early repair of a damaged vessel may prevent severe aneurysms.<sup>41</sup> Excision of a section of a vessel containing the aneurysm with re-anastomosis can be performed if mobilization will give sufficient length. The substitution of grafts for long defects is occasionally being accomplished where non-diseased vessel ends can be made available.<sup>42</sup> Some palliative relief for severe mediastinal

compression can be obtained by resection of the costal cartilages to allow for further expansion of the mass. Some hope is apparently being offered to many of these unfortunate victims.

**CORONARY HEART DISEASE:** Considerable progress is being made in the surgical treatment of coronary disease; however, such surgery as yet must be placed in the experimental class. The surgical treatment of occlusive disease has been based on attempts to increase the vascularity of the heart muscle. Beck<sup>43, 44</sup> and others<sup>45</sup> have sutured adjacent tissues on the surface of the heart and instilled such irritants as asbestos in the pericardial sac to increase myocardial vascularity by the formation of adhesions containing systemic vessels. Vineberg,<sup>46, 47</sup> by implanting the mammary artery in the myocardium, has attempted to increase its arterialization on the premise that the peripheral coronary branches are unaffected by the occlusive process. Thompson<sup>48</sup> has placed magnesium silicate powder over the ischemic myocardium to produce granulomas and adhesions for the development of inter-coronary anastomoses. There was apparently considerable improvement in a rather large number of his patients and the procedure did not involve too much operative risk. Bailey<sup>49, 50</sup> and Beck have recently attempted to arterialize the coronary sinus system by anastomosing the aorta to this vessel by means of a vessel graft. Partial occlusion of the coronary sinus is carried out at a second stage to prevent the myocardial engorgement which occurs if occlusion is performed at the original operation. This allows for compensation of the myocardial capillary bed to the new flow of blood between stages. The partial ligation allows some over-flow through the coronary sinus. Most of the new flow of blood, however, is distributed through the myocardial sinuses and empties into the heart through the Thebesian vessels and thus vascularizes and oxygenates the myocardium in theory.

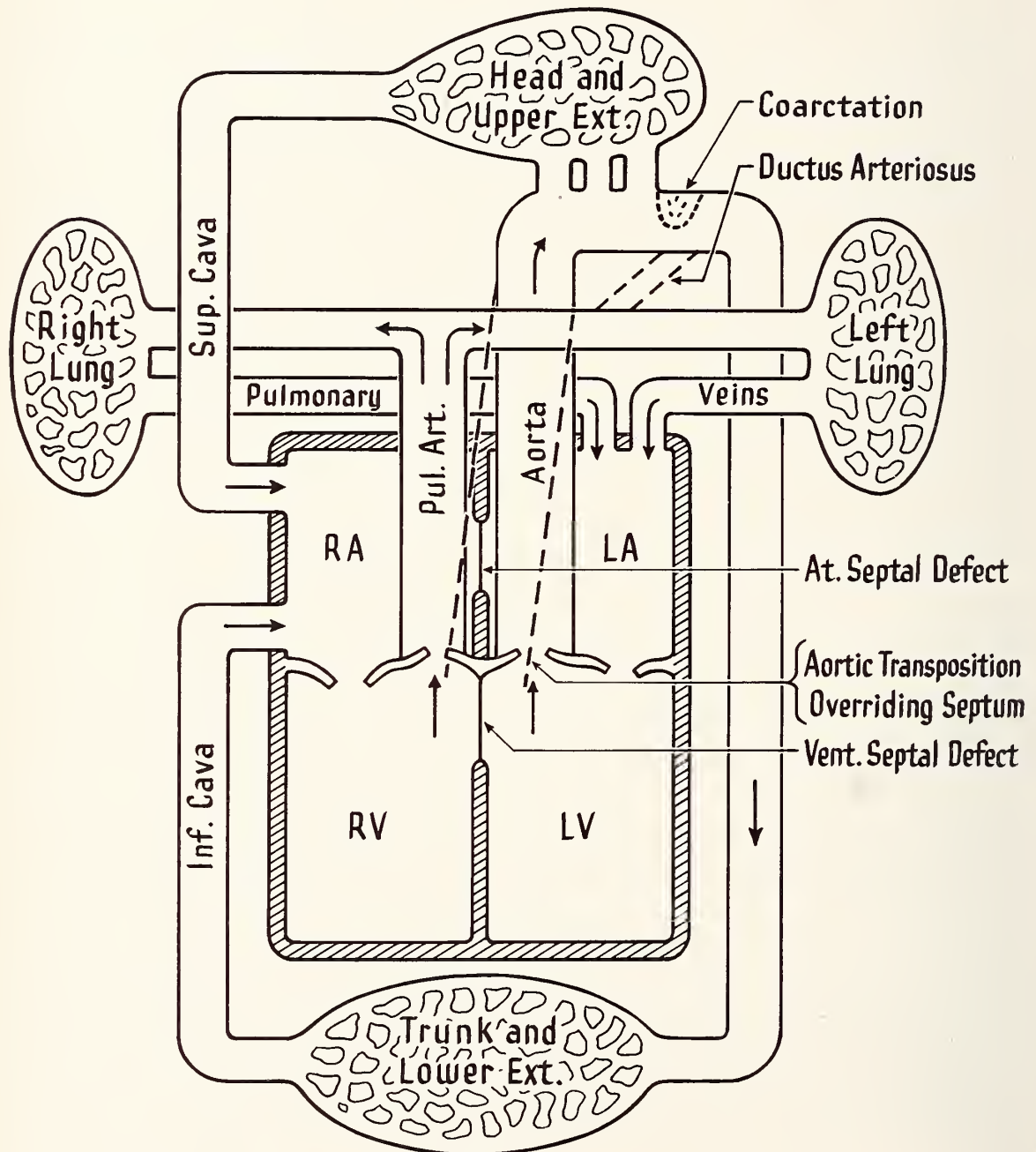
The basic requirements for surgery laid down by Bailey and Beck are that there must be present a progressive major atherosclerotic disease, the diagnosis must be established beyond question and confirmed by persistent abnormalities on the cardiogram, and a significant disability must exist. On the other hand, they believe



that surgery is not indicated where the disease or incapacity is so advanced that benefit or survival seems doubtful. Surgery is not performed until six months have elapsed following infarction and the electrocardiographic pattern is fixed for this period. At present, multiple infarction is considered a contraindication as is heart failure, even though the latter responds to medical treatment. A hypertension of 180 mm. sys-

tolic and 100 mm. diastolic or an increase of heart size of over 10 percent are also thought to be contraindications. The age limit is considered to be 55 years. A calcified aorta technically prevents anastomosis. Significant pulmonary or constitutional disease precludes surgical intervention. Their results have been promising in recent cases although the mortality rate has been rather high.

Pictured below is a schematic drawing, originated by Doctor Thompson and executed by James Glore, I.U. Medical Center artist, to illustrate in a broad sense circulation as it is discussed in the paper by the co-authors.



## CONGENITAL CONDITIONS

### 1. Non-cyanotic Group

**PATENT DUCTUS ARTERIOSUS:** The abnormal physiology of this condition when uncomplicated by other malformations consists essentially of a left to right shunt through the ductus. This produces a strain on the heart and deprives the body of peripheral circulation to some extent while overloading the pulmonary circuit. The diagnosis is based primarily on a continuous machinery-like murmur over the pulmonary area.<sup>51</sup> The pulse pressure may be increased. There is fullness of the pulmonary conus and congestion of the pulmonary hilum on the roentgenogram. The heart is usually not much enlarged. The oxygen content in the pulmonary artery is greater than that in the right ventricle. A catheter can occasionally be inserted into the aorta through the ductus or the ductus visualized by angio-cardiography, though these procedures are rarely necessary. The ductus may close even up to the age of 2 to 4 years, or it may be this age before the murmur is clarified. Rarely is surgery indicated prior to this age. The incidence of endocarditis,<sup>52</sup> aneurysm,<sup>53, 54</sup> reduced activity and life span indicates surgery. The indications must be clear for operations in patients of the older age group as surgery carries considerably more risk than in those of younger age. Cyanosis or decreased peripheral oxygen saturation contraindicate surgery. A complicating endocarditis should be treated first with penicillin therapy.

Division of the ductus between clamps and suture of the ends would appear to be preferable in most instances to simple ligation.<sup>55</sup> Some risk of re-canalization occurs in the latter method. Injury to the recurrent laryngeal nerve must be avoided. Following surgery there may be a temporary hypertension while the diastolic pressure elevates to the degree that it was depressed. The results are excellent and the over-all mortality rate is in the neighborhood of one percent.<sup>56-59</sup>

**CONGENITAL AORTICO-PULMONARY FISTULA:** The findings in this condition are similar to those of patent ductus arteriosus. The fistula may be divided and sutured when the defect is extracardiac and there is no defect in the ventricular

septum. This procedure has recently been carried out by Scott<sup>60</sup> and others.

**COARCTATION OF THE AORTA:** This anomaly consists of a narrowing or constriction of the aorta.<sup>61, 62</sup> There are two general types. The infantile type is marked by a constriction occurring proximal to the entrance of the ductus. The lower peripheral pressure in the distal aorta allows a right to left shunt through the ductus from the pulmonary artery. This causes severe right heart strain and cyanosis of the arterial distribution beyond the point of entrance of the ductus. Heart strain would warrant early operation in an infant with the infantile type. Both the ductus and the coarctation must be repaired. The adult type is usually a shorter constriction and located beyond the exit of the left subclavian artery. This results in hypertension of the head, neck, and upper extremities. Collateral circulation is increased to the lower portion of the body. Pulsating collateral vessels and rib notching can be noted on examination. A systolic murmur is frequently found in the interscapular area. Angio-cardiography will usually demonstrate the defect. Endocarditis, heart failure, rupture of the aorta, and aneurysm are frequent complications of this disease. Aortic insufficiency may be associated with coarctation and is an added indication for operation. Early operation is indicated if there are symptoms referable to the malformation and if there is marked hypertension or electrocardiographic evidence of left ventricular strain. The degree of constriction as indicated by the differential pressures in the extremities or as demonstrated by arteriography may be so slight as not to warrant operation. The surgical risk is greater in adults than in children. The ideal time for surgery is probably between the ages of 4 and 12. Coarctation, in contrast to patent ductus arteriosus, is more frequent in males.

The operative technique varies from patient to patient. It is dependent upon the length, severity, and location of the constriction. A moderate constriction of moderate length located just distal to the left subclavian may be aided by anastomosis of this vessel to the distal segment of the aorta.<sup>63</sup> Resection of the constriction with end to end anastomosis may be done if the constriction is narrow.<sup>64</sup> Long constrictions

which are frequently located in the descending aorta are now being successfully repaired by Gross with the use of preserved grafts.<sup>65</sup> These grafts now have persisted up to five years in certain patients. The large collateral circulation increases the technical difficulties involved. Damaged or thinned out tissues sometimes present certain hazards. The slow release of the clamp on the aorta permitting gradual readjustment of the dynamics of the circulation to the extremities may reduce the risk. Crafoord<sup>66</sup> has kept the aorta clamped for rather long periods during his operative procedures. The results of surgery have been good. The operative risk is approximately five percent.<sup>67</sup>

**ANOMALOUS VASCULAR RINGS:** These abnormalities may consist of the persistence of both bronchial arteries as a double aortic arch; a right aortic arch with left descending aorta and persistence of a ductus arteriosus or a strand thereof; or there may be an anomalous origin of the right subclavian artery.<sup>68, 69</sup> Vessels may encircle and bring pressure upon structures within the mediastinum resulting in stridor, dysphagia, dyspnea, even cyanosis and pulmonary infection. Surgical intervention is indicated only when symptoms are present. The symptoms usually occur in infancy. The diagnosis is confirmed by roentgenologic examinations which demonstrate displacement of the esophagus or pressure on the trachea in the region of the aortic arch. Division of the smaller branch of the double arch, which is usually located anteriorly, is indicated. It should be severed at a point where there is no interference with the blood supply to its branches. Division of the first part of the subclavian artery is feasible, and division of a ductus arteriosus or its strand will relieve pressure upon the mediastinum. Additional relief of pressure can be obtained by suturing the tissues of the anterior mediastinum to the sternum. The results from these operative procedures are good.

**INTERAURICULAR SEPTAL DEFECTS:** These defects are congenital but are inclined to be complicated by rheumatic fever or respiratory infections. A shunt from left to right is usually present due to the higher pressure in the left side of the heart. There is no cyanosis unless the septal defect is so large that it permits mix-

ing of arterial and venous blood in both sides of the heart. Cyanosis may also occur if the condition is complicated by a pulmonary or tricuspid stenosis with increased pressure in the right heart equal to or surpassing that of the left. If the condition is complicated by a mitral stenosis there is a further shunt from left to right with increased strain on the right heart. The condition is termed a Lutembacher syndrome when this complication is combined with the presence of an enlarged pulmonary artery. Anomalous emptying of the pulmonary veins into the right auricle instead of the left is frequently associated with this septal defect. Oxygen saturation of the blood in the right auricle is elevated with a left to right shunt or anomalous emptying of the pulmonary veins into the right auricle. The exploring catheter can frequently be made to pass through the septal defect or into such anomalous veins. Angiocardiography may demonstrate the defect. A marked enlargement of the heart, particularly on the right, occurs in this condition and there also may be a bulging of the left chest wall. A harsh basal systolic murmur is heard to the left of the sternum. There may be a systolic and a mid-diastolic murmur at the apex, particularly if there is a mitral stenosis complicating the picture. A right axis deviation is usually present and there may be widening of the QRS complex and bundle branch block. The pulmonary field is frequently congested on the roentgenogram. Children frequently have stunted growth. Signs of cardiac decompensation may occur. The lesion predominates in females.

Progress has been made rapidly in the past year to the point where consideration must be given to the repair of these defects under certain conditions. The most opportune time for intervention would appear to be when symptoms appear early in life and cardiac damage is not too great. Defects without symptoms probably should be deferred for greater perfection of technique. Lesions found in adults without symptoms or with mild symptoms are probably not subjects for surgery as yet. Pulmonary hypertension probably contraindicates attempted repair of the defect in the present state of our knowledge inasmuch as the defect acts as an escape mechanism to relieve the pressure in the pulmonary circuit. One of the major problems in the repair is to prevent interference with



the inflow and outflow tracts in the right auricle. Anomalous associated pulmonary veins must be diverted into the left heart. Various methods of repair have been tried such as the inversion of the auricular appendages to fill the defect,<sup>70, 71</sup> the use of plastic prostheses,<sup>72</sup> anterior-posterior approximation of the septal region of the auricle by sutures,<sup>73, 74</sup> and the use of ring clamps that exclude the circulation while repair is made of the defect.<sup>75</sup> All of these methods have some faults. The principal one is the inability to repair completely large low defects near the atrio-ventricular ring without interference with the outflow tracts. Open operations have been attempted by excluding the inflow of the blood through clamping of both cavae or by the use of mechanical extra-corporeal circulation. These methods have yet to be perfected sufficiently to maintain circulation and to prevent air embolism through the septal defect into the peripheral circulation.\* Gross<sup>76</sup> has sutured a rubber well to the right auricular wall through which the wall is incised allowing the blood to rise in the well to the extent of its pressure. The palpating finger is inserted through the well to facilitate suture of the defect, if small, or a polythene covering is attached over the defect. He has had several promising results from this method, and it appears to offer good possibilities. Shumacker<sup>77</sup> has sutured a well of plastic material to the atrial wall which is inverted through the incision into the atrium and in an avascular field the material is sutured over the defect. This method offers considerable control and promise. Bailey<sup>78, 79</sup> has used the right auricular wall to repair the defect. The palpating finger is inserted through the appendage into the interior of the heart. The defect is outlined and the wall of the enlarged atrium is sutured around the defect under careful control. He has been able to satisfactorily shunt the caval and coronary sinus circulation into the right auricle and to divert anomalous pulmonary venous circulation into the left heart in a number of cases. Interference with the control mechanism of the heart has been avoided by careful localization

in the region of the coronary sinus. He has been able to perform commissurotomy on the mitral valve in cases of Lutembacher's syndrome at the same time. The finger is inserted through the septal defect into the mitral valve. Commissurotomy should be done prior to closure of the defect in cases of mitral or pulmonary stenosis. The communication acts as something of a compensatory mechanism in the presence of valvular stenosis to relieve pressure. Cases of atrio-ventricular communis are not suitable for repair in the light of our present knowledge. Both the atrial and ventricular septae in the region of the atrio-ventricular valves are deficient in this condition.

**INTERVENTRICULAR SEPTAL DEFECTS:** (*Maladie de Roger*): A left to right shunt also usually exists in these malformations because of pressure differential. There is some strain on the right heart and increased oxygen saturation of the blood in the right ventricle. The defect may be low or high near the atrio-ventricular ring. The high defects are usually associated with other anomalies. An uncomplicated ventricular septal defect is usually characterized by a heart of normal size, very little if any limitation of activity, a systolic murmur and thrill over the mid-sternal region. Most patients are asymptomatic through the early part of life, particularly if the defect is small and low. They are, however, prone to infection. The risk of repair under our present state of technical knowledge does not warrant operation except in rare instances.

The methods of repair that have been developed offer definite possibilities, particularly for defects low in the septum. Pedicled pericardial grafts have been inserted close to the septum to plug the communication.<sup>80</sup> The persistent viability of these grafts over any length of time is in question. Materials may be incorporated in these pedicled tubes to plug large defects. Repair of those defects near the superior portion of the septum and near the auricular-ventricular valves presents considerable difficulty in avoiding obstruction to the outflow tracts of the ventricles.

**ECTOPIA CORDIS:** The displaced heart must be returned to within the thorax early in the neonatal period for the patient to survive. Where this is feasible, plastic reconstruction of the chest wall, abdomen or diaphragm must be done under most difficult circumstances. Frequently,

\* Lillehei and Varco et al recently have utilized a donor individual as an oxygenator with the blood being circulated by a pump in the extra cardiac system. Open operation is performed by clamping the cavae and the aorta close to the coronary vessels to prevent air embolism. Hypothermia reduces the oxygen demand and aids open operation.

associated anomalies of the heart may be present.<sup>81-84</sup>

### CYANOTIC MALFORMATIONS

**PURE PULMONARY STENOSIS:** No cyanosis occurs in this condition if the septae are intact.<sup>85</sup> Cyanosis develops, however, if the stenosis in the pulmonary circuit produces sufficient pressure in the right side of the heart to cause patency of the foramen ovale and a resultant right to left shunt. The right ventricle may enlarge due to increased pressure. There is a dilatation of the pulmonary artery distal to the obstruction but the flow is decreased in the pulmonary vessels. The lung fields are clear as is the pulmonary window on roentgenologic examination. There is a harsh systolic murmur and thrill over the pulmonary area with a weak or absent pulmonic second sound. Pulsation in the margin of the liver, dyspnea, and right side failure may occur in time. Right axis deviation is observed on the electrocardiogram. Catheterization of the heart will demonstrate the decreased pressure in the pulmonary artery in contrast to the increased pressure in the right heart. Angiocardiography will usually demonstrate the obstruction. Systemic-pulmonary artery shunts are contraindicated as they do not relieve the obstruction and merely re-oxygenate blood which is already saturated. Such a shunt would also add to the deleterious effect of obstruction by raising the pulmonary pressures. Operation is probably not necessary if the stenosis is extremely minimal, the patient is asymptomatic and the pressure is only slightly increased in the right ventricle. Otherwise, surgery is indicated, particularly if cyanosis is present. Operative intervention is usually carried out early in life and should be done before the occurrence of cardiac enlargement.<sup>86</sup>

The operative method of Brock<sup>87</sup> is utilized in this condition.<sup>88, 89, 90</sup> Division and dilatation of the pulmonary valve are performed by instruments inserted through the right ventricle. Bleeding is controlled by a purse-string suture in the myocardium surrounding the instruments. Several hundred of these procedures have been performed with good results and a mortality rate of below 10 percent.

**TETRALOGY OF FALLOT:** This condition is characterized not only by pulmonary stenosis or

atresia but by the added defects of dextro-position of the aorta, high ventricular septal defect, and right ventricular hypertrophy.<sup>51</sup> As in all congenital conditions, the greater the defect, the more severe is the pathologic physiology and symptomatology. There is a right to left shunt of blood through the ventricular septal defect and overriding aorta with cyanosis and diminished pulmonary blood flow. Cyanosis may be present at birth but frequently develops later in childhood. The chief symptoms are usually dyspnea, squatting, clubbing of the fingers, and various degrees of failure. The degree of polycythemia and oxygen unsaturation will vary with the degree of the defect. A basal systolic murmur is present but may decrease with severe cyanosis. The heart is usually not enlarged to any degree. The pulmonic second sound is weak or absent. Roentgenograms demonstrate a concave curve in the pulmonic region and the pulmonary window is clear. A right axis deviation is present. The circulation time is shortened and the arterial oxygen saturation will decrease with exercise. Those children who demonstrate a decreased tolerance for exercise, cyanosis and polycythemia can be aided greatly by operation. Patients with a very minimal degree of pulmonary stenosis may be observed but operation is indicated if symptoms develop. The ideal period for operation is from 4 to 10 years of age. The circulatory dynamics prior to this age are undergoing adjustment. However, the more ill the child the more urgent is the indication for operation in most instances. Operation should be deferred if there is a reasonable chance that the child will survive to the ideal age. Several variations of the obstruction in the outflow tract of the right ventricle may be present. These are best differentiated by cardiac catheterization with measurement of the differential pressures in the various segments of the outflow tract and by angio-cardiography. The final evaluation must be made at the time of surgical exploration.

The operative procedure of Brock<sup>91</sup> as noted above is indicated if there is valvular stenosis or a fibrous membrane just proximal to the valve. An infundibulum or second chamber of the right ventricle is observed in a large number of cases. The infundibulum is formed by a fibro-muscular area of constriction located either near the valvular area or more proximal in the outflow tract. Glover<sup>92, 93</sup> is the greatest advo-



cate of the direct approach to these obstructions. He enters the ventricle with a rongeur or pituitary forceps controlled by a purse-string to remove these obstructions. This procedure is not feasible where there is complete atresia, severe hypoplasia of the pulmonary artery, or a long narrow obstruction of the outflow tract of the ventricle. The operative procedures of Blalock<sup>94, 95, 96</sup> and of Potts<sup>97, 98</sup> must be utilized when these conditions are present. These procedures essentially produce a patent ductus between pulmonary and systemic arterial systems. Thus, a fifth defect is added to the syndrome. The shunt essentially re-directs mixed venous arterial blood into the pulmonary vascular bed where it is oxygenated effectively. The Blalock procedure usually consists of an anastomosis of the subclavian artery to the pulmonary artery whereas the procedure of Potts consists of a direct anastomosis of the pulmonary artery to the aorta. Abnormalities of the aortic arch are often associated with the tetralogy. The aorta may arch to the right and may descend on the right, which influences the type of operation performed. The subclavian artery may be too small for anastomosis in infants, and some surgeons advocate that the approach be made on the side in which the aorta descends so that a direct aortico-pulmonary anastomosis can be accomplished if necessary. It is generally accepted, that otherwise, the best approach is on the left where a choice of procedures may be available.<sup>99</sup> An analysis of 1,000 patients operated on by Blalock revealed that 78 percent obtained good results. Relief of symptoms and prolongation of life has undoubtedly occurred in these cases. The operative mortality appears to be in the neighborhood of 10 to 15 percent at the present time.<sup>100, 101</sup>

\* \* \* \* \*

OTHER CARDIAC CONDITIONS have been attended by little or no successful surgical treatment as yet, but work is being carried forward in these fields. Tricuspid atresia may be associated with pulmonary stenosis, and a diminutive

right ventricle.<sup>102</sup> Attempts have been made to relieve this condition in very ill patients by the Blalock procedure which may be combined with the creation of a larger septal defect to relieve pressure in the right auricle. Some benefit has been obtained by this procedure in certain cases of pulmonary atresia or stenosis associated with single ventricle, dextrocardia, dextrorotation, or situs inversus with levorotation.<sup>103, 104</sup> These malformations, however, are likely to be associated with others and the response is not very favorable. Likewise, the creation of a large inter-auricular septal defect has been utilized in the attempt to relieve the symptoms of transposition of the great vessels combined with pulmonary stenosis.<sup>105, 106</sup> The Blalock operation may be attempted when the pulmonary blood flow is inadequate in the case of truncus arteriosus providing there is a rudimentary pulmonary artery in the lung aspect which can be utilized for anastomosis. No surgical means of benefit has yet been discovered for the Eisenmenger complex, Ebstein's malformation of the tricuspid valve and other such malformations. It is to be remembered that various combinations of the several malformations may be present in an individual when consideration is given to surgical therapy.

## CONCLUSIONS

The maximum benefit with the least risk can be obtained from cardiac surgery only when it is performed early before irreversible anatomic and physiologic changes have occurred in the organ. A number of acquired and congenital cardiac conditions can now be successfully treated by surgery with a reasonable risk and there is considerable promise for surgical therapy in still other conditions. Modern methods such as cardiac catheterization have added materially to our means of diagnosis and knowledge of the physio-pathology of the circulation. New techniques such as the use of hypothermia<sup>107, 108</sup> and the possible development of a practical extra-corporeal circulating machine should still further improve the results obtained and widen the scope of cardiac surgery.



## EXPERIENCE WITH MITRAL COMMISSUROTOMY

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**T**HE RECENT DEVELOPMENT of specific surgical procedures for specific cardiac lesions has placed upon the medical field a demand for more exact diagnosis and evaluation of the patient. This started with the correction of certain congenital defects and has more recently spread to include the field of rheumatic heart disease, particularly mitral stenosis. Until this demand was made, it made no fundamental difference if the patient had a pure stenosis, pure insufficiency or combination of valvular lesions because the management of the patient was not particularly altered by this differentiation. The exact separation of the lesions or the determination of their absolute or relative severity was at most an academic exercise which was both interesting and safe because in most instances, it was not possible to have pathological study at necropsy and even when this was possible it was a non-dynamic pathological study rather than that of the living functioning heart. Because of this the development of diagnostic procedures and the literature on this subject were in the main rather indefinite and vague.

With the coming of surgical exploration of the living functioning mitral valve additional knowledge has been accumulated, particularly in the function of the deformed valve and its effect upon the heart as well as an opportunity to frequently evaluate the accuracy of the pre-operative opinion. In addition to this, there have been many opportunities of obtaining biopsy material from an auricular appendage.

With the advent of any new procedure, particularly one as dramatic and potentially dangerous as the correction of an intra-cardiac lesion such as mitral stenosis, there always develops two widely separated groups in the medical pro-

fession—the enthusiasts and the complete skeptics—and each has some merits in its point of view. The majority, probably, fall into that in between group who do not know just what to believe or what principles to follow. They do not wish to deny any patient the right to be helped nor do they wish their patients to take unnecessary and useless risks. They wonder if any patient should have surgery and if some patients should—which ones. They also want an answer to the all important questions—what can the patient gain and what can he lose?

This study of patients who have had mitral commissurotomy was undertaken in an effort to answer these questions, primarily for myself. It was made by evaluating results here in Indiana rather than by a compilation of statistics from the literature concerning patients about which we have had no opportunity to obtain first-hand information. This is also of value because it is here in our own communities where most of our patients will have to be cared for, therefore, important to know what to expect locally.

The material studied does not include all of the patients who have had this procedure in Indiana, but it does, I believe, contain the vast majority. It does include 41 cases which I had an opportunity of personally studying and 12 cases whose medical evaluation was done by physicians whom I know personally and have been able to contact. This makes a total of 53 cases. The cases were selected on this basis only and none were excluded for any other reason.

### GENERAL BREAKDOWN OF CASES

Total number subject to surgery-----	53
Total number of deaths -----	5
Total number of patients operated with-	
in 3 months -----	8
Total number in which nothing was done	2
Total number followed from 4-25 months	38

### AGE AND SEX

There were 33 women and 20 men who fell into the following age groups:

16-19 years-----	1 (17 years)
20-29 years-----	19
30-39 years-----	20
40-49 years-----	10
50-59 years-----	3 (oldest 53 years)

There was no significant variation in the ages between men and women, the average age for women being 35 years and men—32 years. There was no significant difference in the severity of the disease by sex.

### PRE-OPERATIVE FINDINGS

*Dyspnea*—All patients in this group had or had had at least moderate shortness of breath and dyspnea so that it was necessary for them to definitely curtail their physical activity.

*Auricular Fibrillation*—Twenty-three patients or 43% had a fixed auricular fibrillation before surgery and none have converted spontaneously. An attempt to correct this rhythm postoperatively was made in two patients. One was successful. One patient had paroxysmal fibrillation before surgery and has continued this postoperatively. Five patients or 16% of the patients with sinus rhythm developed postoperative auricular fibrillation while still in the hospital. Four were converted with quinidine and one was not. The patient has continued to fibrillate. We know of no other patients who have started to fibrillate postoperatively.

*Emboli*—There was a history of peripheral embolization in seven patients or 14%. Of these, only two were found to have clots in the auricles or atrium at time of surgery even though a total of seven or 14% were found to have clots at surgery. All of the patients with embolization were fibrillating and consisted of 30% of this group. On microscopic section, approximately 17 were found to have microscopic clots of the auricular appendage. No patient has had any clinical embolus after discharge from the hospital.

*Congestive Failure*—Eight patients were observed to have edema while in the hospital preoperatively and there was a history of edema in an additional 28 making a total of 36 or

68%. No patient was permitted to go to surgery with frank failure although there were seven operated upon while they had some signs of failure other than dyspnea, namely, liver enlargement.

*Hemoptysis*—Twenty-four patients or 45% had a history of hemoptysis of varying degree. There were 12 men and 12 women. All patients who have been classified as having a good result on other criteria have had no recurrence of this symptom during the period of observation.

*Mitral Insufficiency*—Twenty-four patients or 45% were considered clinically to also have mitral insufficiency. Of this number, 19 were found to have a systolic regurgitation of blood in the atrium at surgery and so were considered to have mitral insufficiency. This discrepancy of five cases probably is because the patients did not have insufficiency, but it may be because of the disturbed dynamics secondary to surgery and to the introduction of the surgeon's finger into the atrium. There were also five patients who were found to have insufficiency at surgery which was not diagnosed clinically. The degree of insufficiency was considered to be slight. In all cases classified as marked insufficiency preoperatively, this was found at surgery and no cases of marked insufficiency were found at surgery which had not been diagnosed previously.

*Electrocardiogram and X-ray*—All patients had electrocardiograms using at least 12 leads and x-ray studies including fluoroscopy. On electrocardiogram, 19 or 36% had no indication of hypertrophy. Thirty-one or 60% had right ventricular hypertrophy, two or 4% had left ventricular hypertrophy and two or 4% had combined right and left ventricular hypertrophy. By x-ray, 36 or 68% had findings interpreted as the result of mitral stenosis alone and 16 or 30% had evidence suggesting mitral insufficiency and/or an aortic lesion and one case or 2% was normal.

*Functional Classification*—All patients were placed in the functional classifications—I through IV—as suggested by the New York Heart Association.

Class I-----	0 ( 0%)
Class II-----	20 (38%)
Class III-----	26 (50%)
Class IV-----	7 (14%)

*History of Rheumatic Fever*—A definite history of rheumatic fever was obtained in 24 or 45%. The time lapsing was as follows, the average being 18 years.

2-9 years-----	5 (shortest 2 years)
9-19 years-----	10
20-29 years-----	6
30-39 years-----	3 (longest 38 years)

### FINDINGS AT SURGERY

*Mitral Insufficiency*—Twenty-four or 46% of patients were found to have a regurgant systolic jet in the atrium at the onset of surgery so were thought to have mitral insufficiency. Of these, 11 were considered to be slight and 13 considered severe.

*Clots*—Seven or 14% were found to have auricular or atrial clots. All of these were in fibrillating auricles. In two cases the clots were so extensive and fixed that the atrium could not be entered.

*Calcium*—Thirteen patients or 25% were found to have calcium in the valve or in the region of the valve. Of these, it was present in sufficient amount to interfere substantially with the surgery in four patients or 8% of the total cases operated upon.

### ANALYSIS OF SURGICAL PROCEDURES

*Cases in which little or nothing was done*—There were 15 patients or 28% in whom little or nothing could be done for the following reasons:

Too much calcium -----	4
Abnormality of chorda tendineae-----	2
Almost pure insufficiency -----	5
Too extensive clot -----	2
Rupture of the myocardium at surgery with death -----	1
Essentially normal -----	1

The patient in which an essentially normal valve was found deserves special comment. She was a 41-year old woman who was found to have a very slight insufficiency and almost no stenosis at surgery. She had a rather marked psychogenic overlay, but the history of hemoptysis, dyspnea and slight edema seemed to be well substantiated. She had a normal electrocardio-

gram and x-ray and only a slightly accentuated pulmonic second sound and a diastolic murmur which was very soft, if in reality it was present. She has been markedly improved by the procedure according to her own account. The absence of positive findings before surgery precludes any clinical evaluation other than history as to her postoperative result.

*Cases in which only a partial or incomplete commissurotomy was done*—There was a total of 38 patients or 70% in whom it was possible to do a commissurotomy. Of the 38, 26 were thought to have had a very satisfactory opening of the mitral orifice and 12 were thought to have been benefited. This means that 50% of the total operated upon received an excellent technical result and 24% received good but less perfect result.

*Predicted results at completion of surgery*—Of the 52 patients who survived surgery, 26 or 50% were predicted to have a good result and 26—a poor result by analysis of the technical results. The correlation of predicted results with the actual results in the patients who have been followed over 3 months is as follows: 19 who were predicted good are good, two who were predicted good are poor, (one had a marked mitral insufficiency and developed rheumatic fever two months postoperatively, the other developed a postoperative fixed auricular fibrillation), and 10 who were predicted to have poor results are good. Some of these are those in whom very little or nothing was accomplished, and nine who were predicted poor are poor. One patient who had a predicted good result died postoperatively of cerebral embolus and three patients predicted poor died in the early postoperative period of cardiac insufficiency.

### COMPLICATIONS DURING SURGERY

*Mitral Insufficiency*—Five slight and one marked mitral insufficiencies were produced by surgery. In only two patients was a pre-existing insufficiency thought to have been increased by the procedure.

*Myocardial Tear*—This complication occurred four times resulting in one death and interfering with satisfactory completion of the separation of the valve in another. Three of these were in



the ventricle and were associated with marked calcium deposits and one was in the atrium.

*Calcium*—In six patients, the calcification of the valve and area of the valvular attachment was so great that it interfered with completing the separation of the commissure. In three, the calcium was thought to have been a contributing factor to a tear in the ventricle. In one patient a piece of calcium was felt to break off, but no clinical embolization occurred.

*Embolism*—One patient was very slow in recovering from the effect of the anesthesia and when he did he was found to have a complete right hemiplegia. He died on the first postoperative day. He was a patient who had been fibrillating, had clots in the atrium and had a markedly calcified valve.

*Hypotension*—Some degree of hypotension was experienced in many patients and although the cardiac output essentially falls to zero during the time that the surgeon's finger is in the valve, this complication was only encountered once in the degree to seriously interfere with the surgery.

### POSTOPERATIVE COMPLICATIONS

*Pleural Effusion*—This complication occurred many times and occasionally required tapping but was only a severe enough problem in two cases to significantly affect the convalescence. One of these had a hemothorax and the other occurred late after the patient had returned home and produced a marked dyspnea which was relieved by aspiration.

*Embolization*—There was only one clinical embolization during the postoperative period in the hospital and this was to the spleen. It occurred in a man who was fibrillating and had clots in the atrium. It did not seriously affect his convalescence. No patient has developed emboli after leaving the hospital.

*Atrial Fibrillation*—This complication developed postoperatively in five patients. This represents 16% of those with sinus rhythm. Four were converted rather easily with quinidine and one was not converted and has continued to fibrillate. No other patient who had sinus rhythm at the time of surgery had developed auricular fibrillation.

### SELECTION AND CLASSIFICATION OF PATIENTS

No patient was operated upon who was considered to have asymptomatic mitral disease and they were all considered to be definitely incapacitated. In seven patients the surgery was undertaken more or less as a last resort mainly on the insistence of the patient and the patient's friends. Six of these patients were considered to have a marked insufficiency, but a stenotic component could not be ruled out. In the remaining 47 patients it was felt that the major problem was mitral stenosis even though they may have had some mitral insufficiency or an aortic lesion. It was also felt that they all had a disability which was progressing or in other words they had reached the critical level in a degree of obstruction of the mitral valve.

*Grouping of Patients*—On the basis of the entire clinical picture including history, physical examination, x-ray and electrocardiogram, and occasionally cardiac catheterization, all patients who were being considered for mitral commissurotomy were placed into one of four groups.

Group A—Patients with rheumatic valvular disease who are essentially asymptomatic.

Group B—Patients with pure mitral stenosis and whose symptoms were such that they would be class II or III.

Group C—Patients with combined mitral stenosis and insufficiency in which it was thought that insufficiency was contributing very little to the patient's disability and who were in class II or III.

Group D—Patients whose lesion was predominantly an insufficiency or those patients with predominant mitral stenosis who are classed in class IV.

In this series of 53 patients they were grouped as follows:

- A—none
- B—28 (53%)
- C—15 (28%)
- D—10 (19%)

## ANALYSIS OF RESULTS

Because of the difficulty in definitely classifying the patients as to their results, they have been divided into only two groups—good and poor—with an attempt being made to grade down, rather than up, any questionable case. The result is considered to be good if the patients have been definitely benefited even though still requiring some cardiac management. All other results are classified as poor. There is, of course, a gradation in each group. This gradation is very hard to evaluate unless the patient can be seen often and during their daily tasks. The tremendous psychic effect of this type of procedure particularly in those patients who had felt that their condition was a hopelessly progressive one can not be definitely assayed. This has been noticed in a few patients in whom nothing was done, who feel that they have been helped a great deal. As unreliable as is the history, it is an integral part of the patient's postoperative evaluation and must be considered.

Classification of the results has been made as impartially as possible and is based on history and on our own observations and physical examinations. It is admitted that this method will contain many errors and yet it seems to be as reliable as do many of the catheterization studies and other more complicated methods. Be that as it may, it is the clinical evaluation of the patient that the vast majority of us must rely upon in evaluating any therapeutic procedure, especially one which involves such a complex entity as cardiac function.

*Overall Results*—The overall result of this series of 38 patients who were observed from 25 to 4 months was 26 patients or 67% good and 12 or 33% poor.

*Mortality*—Four patients died postoperatively while still in the hospital and one patient died during surgery. No patient has died after leaving the hospital. A breakdown as to the cause of death shows that one died as the result of a cerebral embolus which occurred during surgery. One died of a torn ventricle at time of surgery. Three died of cardiac insufficiency in the early postoperative period. All of these three were fibrillating and had been placed in group D because of a marked mitral insufficiency and were class IV patients. In each of these three patients, a marked insufficiency was found at surgery and

very little or nothing could be done. The overall mortality rate is 9% and by groups—B 8% C 0%, D 30%.

*Results of Functional Class—New York Heart Association—*

	II	III	IV
Died -----	2	0	3
Poor -----	6	1	3
Good -----	13	14	1

*Results by Electrocardiograms—*

	Normal	RVH and LVH	RVH	LVH
Died -----	3	1	0	1
Poor -----	3	5	1	1
Good -----	8	19	1	0

*Results by X-ray—*

	Normal	M.S. and M.I. or A.S. only	M.S. and M.I. or A.S.
Died -----	0	2	3
Poor -----	0	3	7
Good -----	1	21	6

*Results by Groups—*

	A	B	C	D
Died -----	0	2	0	3
Poor -----	0	3	3	6
Good -----	0	19	8	1

The two deaths in group B consist of one case which had a cerebral embolus during surgery in a patient who was fibrillating and who had a clot in his atrium and a calcified valve; there had been a good technical result. The other death in this group was due to a tear in the myocardium at the time of surgery; there was a marked calcific deposit. One of the poor results in group B was due to the production of a marked mitral insufficiency at the time of surgery. The patient also developed acute rheumatic fever two months postoperatively. She was a 24 year old woman with a pure stenosis and class III. She is no worse following surgery, neither is she any better. The two other poor results in this group were patients who had such a marked amount of atrial thrombosis that the mitral valve was inaccessible and nothing was done. In group C the three cases that were re-

ported as poor consisted of two cases in which there was too much calcium to perform an adequate commissurotomy and one case in which there was a rather marked insufficiency and who also has developed a fixed auricular fibrillation, postoperatively. The good result in group D was a patient who had an almost pure stenosis, but was in class IV. The others in this group were found to have a marked mitral insufficiency at surgery.

*Murmurs and Thrills*—At this time only general statements can be made in regard to murmurs and thrills. In almost all of the patients in which a satisfactory technical result was obtained the diastolic murmur disappeared after surgery. In a few of these it was only lessened in intensity. In those in which only a partial commissurotomy was possible, some had complete disappearance of the murmur, but for the most part it was only lessened in intensity. In one case, a new loud cystolic murmur appeared, but this was in a patient in whom it was known that a valve had been torn. In a few others, there was a new soft systolic murmur. In some of these, but not in all, it had been recognized that the valve had been torn slightly. In some of these cases, but not all, the systolic murmur has disappeared with a lapse of time. In a significant number of patients who had lost their diastolic murmur it has returned in the months following surgery. The significance of this is not known and will require the passage of more time before evaluation. It is, of course, feared that it is the result of a return of the mitral stenosis. One patient who had only a grade II systolic murmur before surgery and who was found to have a pure stenosis at surgery has lost the systolic murmur and it had not returned in seven months.

*Biopsy of Auricular Appendage*—The complete study of these has not been finished. There are 49 which are being studied. In 25 or 50%, there are cells which resemble those found in the Aschoff body. As yet, the pathologist who has

examined these has not found what he considered to be a true Aschoff body. In 17, evidence of some microscopic mural thrombosis was found. The above-mentioned special cells were seldom seen in connection with this microscopic evidence of mural thrombosis. The true significance of this observation is not apparent at this time, but is being considered.

## CONCLUSIONS

1. Mitral commissurotomy is a new and yet unevaluated surgical procedure.
2. It is known that some patients have been markedly improved, some being returned essentially to normal for as long as two years.
3. The expected duration of improvement or whether any are cured or not is unknown.
4. It is not known whether stenosis will reform or not. If it does reform, it is not known how long it will take or what the degree of reformation may be. There is some evidence that it may reform.
5. There is a definite mortality and morbidity even in the best selected cases and these rates increase as the contraindications for the surgery increase.
6. The classification of patients in groups A through D as described has been a definite help in determining the advisability of surgery and in prognosticating the results and mortality. Patients in group B will probably receive a good result. Patients in group C may receive a good result. Patients in group D should probably not be operated upon except for rare exceptions.
7. Patients in group A, those with asymptomatic mitral stenosis and those without progressive symptoms should not have surgery now. They should wait until the procedure has been evaluated. They should also wait so that if surgery proves to be only a temporary relief they should have this relief when it will do them the most good.



# ACUTE THYROIDITIS

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**T**HYROIDITIS has been termed both acute and subacute, depending upon the author's experience with the clinical picture. Synonyms include pseudotuberculous thyroiditis, tuberculous thyroiditis, sclerosing tuberculosis, struma granulomatosa, granulomatous thyroiditis, giant cell thyroiditis, acute simple thyroiditis, acute non-infectious thyroiditis, and acute non-suppurative thyroiditis. The disease is self-limited, and occurs in a previously normal gland. The course is variable, lasting a few weeks or months, subsides spontaneously, and leaves no residual interference with thyroid function.

The fulminating type with fever, pain, tenderness, and systemic symptoms is generally termed acute non-suppurative thyroiditis and is treated by medical management. The chronic type with few of these manifestations has usually been called granulomatous or giant cell thyroiditis and has been treated by thyroidectomy. Between these two extremes are many cases which present all combinations of systemic and local symptoms, frequently not recognized because of the confusing picture and lack of localizing signs.

## ETIOLOGY

The cause is unknown. No specific organism has been isolated. Frequently the onset occurs after an upper respiratory infection. Measles, malaria, and scarlet fever have been noted as antecedent diseases. This suggests a viral agent as the most likely possibility. The prolonged chronic inflammatory process may be the result of a foreign body reaction to colloid which escapes into tissue spaces when the cells lining the follicles have been damaged by the virus infec-

tion. It is six times more common in females and is usually seen in the 40-50 age group.

## PATHOLOGY

The thyroid may be two to three times enlarged in a symmetrical manner. The gland is diffusely involved. The microscopic picture is a subacute inflammatory process. There is an infiltration with leukocytes and foreign body cells. Tubercle-like formations are seen. Histiocytes produce a typical foreign body reaction by engulfing the colloid in the degenerating follicles. Fibrosis is present.

## CLINICAL PICTURE

Tenderness, pain on swallowing, with radiation of pain to the ear, and local swelling of the gland are present. The consistency of the gland is abnormally firm. Occasionally the process will start in one lobe and spread gradually to involve the entire gland. Sometimes it has completely subsided in one lobe by the time the other is involved. This has been termed "creeping" thyroiditis. Fever, chills, nervousness, weakness, fatigue, tachycardia, sweating, and tremor are the systemic manifestations. The clinical picture is that of a toxic reaction rather than hyperthyroidism.

## DIAGNOSIS

Acute thyroiditis must be distinguished from other well-recognized forms of thyroiditis.

### (1) *Struma lymphomatosa* (Hashimoto)

No relationship exists between this disease and acute thyroiditis or Riedel's struma. It occurs insidiously in the 40 to 50 age group, usually in women. Pain may be present at the onset, but to persist

is unusual. There is no systemic reaction except a mild hypothyroidism. The gland may feel adenomatous and asymmetrical. Tracheal encirclement with compression or obstruction may occur. There is no spontaneous remission. The microscopic picture is characterized as an acidophilic degeneration of the thyroid epithelium with replacement by lymphocytes and fibrous tissue. The inflammatory process is contained within the surrounding capsule, without extension. X-ray therapy is effective, but the diagnosis is seldom made until after microscopic examination. Therefore, the usual treatment is lobectomy or thyroidectomy. Thyroid administration is also beneficial.

(2) *Riedel's struma*

This is a rare condition found after the age of 50 in women. A bulky tumor is produced that may be indistinguishable preoperatively from carcinoma. The thyroid enlargement is stony hard and fixed to the surrounding structures. It is painless, slow growing, and produces symptoms of pressure and tracheal obstruction. The microscopic picture is a chronic inflammatory reaction with fibrous tissue replacement centered about a degenerating adenoma. The capsule and surrounding structures are infiltrated, so that the disease is really a diffuse fibrosis of the neck with thyroid at its center. Fibrous tissue is laid down in layers to form concentric rings like an onion. The only beneficial treatment is surgery for relief of the tracheal obstruction.

(3) *Lymphoid thyroiditis*

A progressive diffuse thyroid enlargement occurs in females from 20 to 40 years of age, often after childbirth. The gland may enlarge to three or four times normal size with mild pressure symptoms. A mild hypothyroidism is present. The microscopic picture is similar to Hashimoto's disease except acidophilic epithelium is not present and fibrosis is minimal. Dramatic results occur with the administration of thyroid extract. The enlargement of the gland subsides and the firm consistency disappears. Cortisone

and x-ray therapy have also been reported as beneficial.

Acute thyroiditis must be differentiated from nodular goiter, carcinoma of the thyroid, Grave's disease, and pharyngitis. If only one lobe is involved it is easily confused with a thyroid adenoma or malignancy. The most helpful diagnostic feature is that usually the entire lobe is diffusely involved so that it retains the normal contour, thus differing from an adenoma or carcinoma. The diagnosis is usually made without difficulty on clinical grounds.

The BMR is normal or slightly increased. The sedimentation rate is accelerated. The thyroid gland takes up little or no radioactive iodine. Tracer studies usually show low uptakes in the neighborhood of 5 per cent compared to 30 to 50 per cent uptake by the normal thyroid, and to 60 to 90 per cent uptake in hyperthyroidism. This low uptake can be explained either by damage to the thyroid epithelium by the virus infection, or by the absorption of preformed colloid which had escaped into the tissue spaces. This last hypothesis would best explain the systemic symptoms simulating hyperthyroidism. The rapid absorption of preformed colloid could produce a clinical picture of artificial or induced hyperthyroidism, similar to that of the administration of desiccated thyroid.

The diagnosis in questionable cases may be ascertained by biopsy, using the Silverman needle. This obviates the need for surgical exposure of the thyroid.

## TREATMENT

Untreated cases persisting a year or more are on record. Hot and cold wet packs have been used to no avail. Iodides are also ineffective. Radioactive iodine is of no benefit. All of the antibiotics have been used without altering the clinical course.

### Case No. 1

This 44 year old white female was first seen on May 7, 1948, because of pain in the right side of the neck for five weeks. The pain was dull, aching in character, and aggravated by swallowing. The thyroid was not enlarged, but marked tenderness was present over the right lobe and moderate tenderness over the left. The BMR was plus 1. During her hos-

pitalization the patient developed an intermittent fever with temperatures to 101 degrees. She was treated with penicillin—50,000 units every three hours—which seemed to produce a partial improvement. However, a week later the patient was seen with a recurrence of symptoms, now predominantly over the left lobe of the thyroid.

#### Case No. 2

This 29 year old white female was first seen on December 21, 1950. Five days previously the illness had begun with pain in the neck anteriorly, extending upward to the back of the head and associated with headache. The throat had been feeling tight, but not superficially sore. Dysphagia was present with inability to swallow solid food. She tried to clear her throat by straining rather than by coughing. There was no antecedent upper respiratory infection. The patient appeared to be acutely ill and prostrated. Movement of the neck was associated with great apprehension and reluctance to swallow. The patient spoke in a hoarse whisper. The anterior neck was exquisitely tender over the area of the thyroid gland, so that the lightest palpation was painful. It was felt that the patient had an acute thyroiditis. The blood count was 12.5 grams of hemoglobin or 80 percent, RBC 4,460,000, WBC 5,900 with normal differential. The patient was febrile during her hospitalization. She was treated with 600,000 units of penicillin four times a day initially, then with a gradually tapering dose for two weeks. Six months later the patient still had slight tenderness and a feeling of fullness in the thyroid. This was not severe, but still annoying. There was no dysphagia nor systemic manifestations.

Thyroidectomy is occasionally performed when the disease is not recognized clinically. Sometimes the removal of a single lobe will suffice. Excision of the gland is effective, although not justified when less radical therapy is more satisfactory.

#### Case No. 3

The patient was a 36 year old white female who was seen on July 5, 1950, because of a mass in the right side of the neck for the past four years. The gland had slowly increased

in size. No exophthalmos was present. A firm, tender mass was present in the right lobe of the thyroid. Some nodularity was also present on the left. A subtotal thyroidectomy was performed with removal of the right lobe and a small portion of the left. X-ray therapy was also given following operation. The pathologic report described the gland as densely infiltrated with lymphocytes, with many large lymphadenoid follicles. Most of the acini were small and lined with eosinophilic cells, but large acini were also seen with retention of colloid and residual epithelial spurs. The histologic picture was thought to be similar to, but not identical with, Hashimoto's disease and was classified simply as chronic thyroiditis.

In 1945, King and Rosellini<sup>1</sup> first reported the use of thiouracil in the treatment of thyroiditis. There were some relapses. A delay occurred before relief was obtained. Drug intolerance and agranulocytosis were occasional side-effects. If the foreign body reaction is due to the presence of colloid, thiouracil effectiveness can be explained on the basis of interference with the formation of this substance.

The results of x-ray therapy have been consistently good. Crile<sup>2</sup> reported 35 cases treated with x-ray therapy with doses ranging from 250 to 2,000 roentgen units. However, 600 to 800 roentgen units was the average, given in fractional doses over four days. Response to treatment was uniformly good. Fourteen of the patients showed a complete relief of pain within a week and nine showed a striking diminution in the size of the gland within the same period of time. However, on an average, pain and tenderness disappeared by the thirteenth day and the thyroid was no longer enlarged at the end of 30 days. With x-ray therapy the remission rate ranges from 17 to 27 percent, the interval between attacks being approximately six weeks. Recurrences are usually in a milder form and require a second course of treatment. Occasionally undesirable effects are seen, such as hypothyroidism. This is not apt to occur with the average dose of therapy. The number of visits required for therapy, the cost, the delay in obtaining subjective relief, and the high recurrence rate are all disadvantages of this type of therapy.



**Case No. 4**

A 43 year old white female was examined on June 28, 1952, and found to have a very tender left thyroid gland with swelling. The clinical impression was acute thyroiditis in the left lobe. The patient was given 500 roentgen units of x-ray therapy. These treatments were given over a period of ten days with a prompt subsidence in her symptoms. There has been no recurrence.

**Case No. 5**

This 36 year old female was first seen on January 2, 1951, because of difficulty in swallowing of three days' duration. Dysphagia first occurred with solid food, but had progressed so that even swallowing water was accomplished with difficulty. Examination revealed a visible fullness at the base of the neck in the midline and over the right lobe of the thyroid. Palpation of the mass was painful. Hoarseness was present. The patient appeared toxic, prostrated, and dehydrated. The diagnosis of acute thyroiditis was established clinically. X-ray therapy was administered in four daily doses of 100 roentgen units each. Thirteen days later the patient was improved, but some tenderness remained over the thyroid gland. Three weeks after treatment the tenderness and swelling had disappeared, but the subjective complaint of fullness and tightness of the throat persisted.

**Case No. 6**

This 46 year old white female was first seen on February 21, 1952, and hospitalized for 10 days. She was admitted to the hospital because of chills and fever with a temperature of 104 degrees. The shaking chills were followed by fever every evening, in a cyclic manner. Associated were drenching night sweats and a feeling of intense weakness. A slight productive cough was also present. For three months prior to examination she had a feeling of soreness in the throat and a tight feeling on swallowing. Pain radiated upwards into the ears. Twenty years ago she was thought to have a goiter, but this disappeared with no further difficulty with the throat until the present illness. Physical examination revealed a mass at the base of the neck measuring 3 by 3

cm. This mass was slightly tender and felt to be within the right lobe of the thyroid. There were a few fine rales on deep inspiration in the right lower lobe of the lung posteriorly. The diagnostic possibilities considered were virus pneumonia, thyroid adenoma, and acute thyroiditis.

The blood count revealed 12.1 grams of hemoglobin or 78.3 percent. RBC was 3,810,000, WBC 8,550, with a normal differential count. The urinalysis, electrocardiogram, malaria smears, blood culture, and chest x-ray were all negative. Both typhoid and brucella agglutinations were weakly positive in 1:160 dilution. During the hospitalization the patient had a daily spiking fever which occurred with clock-like regularity at 10 p. m. each evening. The temperature returned to normal by morning. The pain in the neck was aggravated each time before a chill and the thyroid was found to be more tender at this time.

Terramycin, 500 mgm every six hours, exerted no change in the temperature. Because of the brucella agglutination a diagnosis of acute brucellosis was temporarily considered. 500 mgm of aureomycin every six hours was given concurrently with 0.5 gm of dihydrostreptomycin every 12 hours for six days. The patient's condition remained unchanged with daily temperature spiking, but only to 101 degrees. The radioactive iodine uptake was less than 4 percent. The brucella and typhoid agglutinations were repeated and found to be negative. The tenderness migrated from the right to the left lobe of the thyroid gland. The patient was given 200 roentgen units of x-ray therapy to the thyroid gland daily for four days. Within 16 days following treatment the thyroid had decreased partially in size and tenderness was no longer present. Forty-five days after treatment the swelling in the neck had completely subsided. There has been no further difficulty.

**Case No. 7**

This 46 year old white female was first seen on March 4, 1952. At 15 years of age she had a goiter which disappeared. About February 1, 1952, the patient developed a soreness and swelling of the right side of the neck. There was a sensation of a lump in the throat, which

had gradually grown larger with an increased amount of soreness. It was especially difficult to swallow with the head held in extension. She had been having occasional chilling sensations and intermittent fever with night sweats. The left side of the neck was normal. The right side was tender over the right lobe and isthmus of the thyroid. The right lobe was firm, enlarged, and readily seen on profile. The BMR was plus 4. X-ray therapy was initiated because of the clinical diagnosis of acute thyroiditis. A total of 800 roentgen units were administered in divided doses. Initially, during the course of therapy, the swelling increased temporarily, but subsequent improvement occurred. The mass in the neck completely disappeared within 50 days.

The first report of the administration of ACTH to a patient with an infectious disease was made in October, 1950, by Dr. Maxwell Finland and his co-workers, who administered the hormone to a patient with severe pneumococcus pneumonia. A prompt disappearance of all the symptoms and most of the signs of the clinical pneumonia resulted. However, the blood culture remained positive and the anti-pneumococcal antibodies appeared at the anticipated time.

The adrenal steroids resulting from ACTH administration exerted no effect upon the growth of the organism, but did completely neutralize the effect of the toxins produced by the organisms upon the cells of the host. Perhaps the adrenal steroids destroy or absorb the toxin much as diphtheria antitoxin neutralizes diphtheria toxin. Possibly the permeability of the cell membrane is affected, thereby preventing the entrance of the toxin. It is conceivable that the adrenal steroid acts within the cell itself, in some way protecting the enzyme system from becoming disrupted.

There is now general agreement that the hormones do not act specifically against any disease or group of diseases, but inflammatory or hypersensitivity reactions provoked by many different agents may be reduced by their administration. The results are usually temporary, but when employed in responsive conditions they may inhibit the pathologic process while the disease runs its course. In some mysterious way certain tissue reactions to adverse stimuli are altered. At any

rate, the adrenal steroid acts as a non-specific blocking agent.

The adrenal steroids suppress thyroid activity through pituitary inhibition by decreased secretion of thyroid stimulating hormone. Cortisone has been observed to depress the uptake of radioactive iodine by the thyroid gland. This seems to indicate that cortisone effects a reduction in hormone production and colloid formation.

Pituitary ACTH causes a stimulation of the adrenal cortex, resulting in a hypertrophy and hyperplasia. The effect of cortisone is the opposite with atrophy developing. Within the past four months, three deaths have been reported following operations on cortisone-treated patients with postmortem findings of adrenal atrophy.<sup>3, 4</sup> Cortisone suppresses pituitary function and the secretion of ACTH, producing secondary adrenal cortical atrophy.

In such patients the adrenal can be stimulated to resume production of hormone by exogenous ACTH, but only after a latent period of several days. When cortisone is withdrawn rapidly, asthenia and acute adrenal insufficiency may result. The withdrawal of ACTH seldom leads to an Addisonian-like state. Thus, there is risk in surgery and stress states when an individual receives long-term cortisone treatment. A supplement should be given when a medical or surgical emergency arises.

The physiologic effects of these hormones are well known. However, some of these may develop into undesirable side effects and must be anticipated. These may conveniently be classified into various metabolic categories.

- (1) *Carbohydrate metabolism:* The administration of cortisone or ACTH might cause the impairment of tolerance for carbohydrate producing hyperglycemia and glycosuria. Such exaggerated diabetogenic effects may indicate that latent diabetes existed prior to the administration of the hormones. Likewise, an intensification of pre-existing diabetes by cortisone has been observed.
- (2) *Electrolyte and water metabolism:* The effects are somewhat variable and in some circumstances there may be a retention of salt and water, producing edema, and in others salt and water are excreted in in-

creased amounts. Both hormones have the capacity to cause retention of sodium and promote the loss of potassium. This tendency is much greater with corticotropin than with cortisone. Corticotropin stimulates the secretion of cortisone-like steroids as well as desoxycorticosterone-like hormones. Hypertension, edema, and congestive heart failure may be aggravated.

The hormones have been observed to cause hypochloremic, hypopotassemic alkalosis. Excessive potassium excretion occurs with a diminution of intracellular and extracellular potassium and the development of a negative potassium balance. This may result in an impairment of cardiac function recognized clinically by electrocardiographic changes, namely, a prolonged QT and PR interval with an inversion of the T waves. Low blood chlorides and alkalosis are especially prone to occur if mercurial diuretics are given to promote water excretion.

- (3) *Protein metabolism:* There is a loss of nitrogen from the body indicative of an increase in the catabolism of protein under the influence of these hormones. Pronounced creatinuria and an increase in the excretion of uric acid also has been noted.
- (4) *Fat metabolism:* Transient ketonuria has been observed as well as a decrease in the level of serum cholesterol esters. Grossly, there may be a redistribution of fat depots in the body. A Cushing-like syndrome may appear as a late complication manifested by hirsutism, acne, hypertension, rounding of the facial contour, muscular weakness, and any of the above metabolic complications.
- (5) *Hormones:* Menstrual irregularity occurs occasionally with the development of amenorrhea. There are androgenic effects with the production of acne and hirsutism.
- (6) *Psychic effects:* A wide variety of psychic reactions have been produced with

mild degrees of depression or stimulation, euphoria, manic behavior, and frankly psychotic states.

- (7) *Miscellaneous effects:* These hormones may increase the secretion of gastric acids and pepsin and may aid the reactivation of a healed peptic ulcer or produce a new one during treatment. Prolonged administration of the hormones may produce excessive calcium excretion with resultant osseous demineralization and osteoporosis. Cortisone also affects the enzyme systems involving hyaluronidase and histaminase. There is an inhibition or reduction of the spreading factor and a rise in the level of histaminase, curbing the local formation of histamine.

Intercurrent infections are masked so that the clinical evidence of disease is minimal or absent, while the infection goes on unhindered. Infections of a serious or fatal nature have developed, the symptoms of which were concealed while the patient was under the influence of the hormones. This is especially true of tuberculosis, in which the spread of pulmonary lesions may be accelerated. Cortisone should not be given to patients with acute or chronic infections due to staphylococci, streptococci, meningococci or pneumococci. If an infection supervenes during the administration of these hormones, early treatment with adequate doses of the appropriate antibiotic is most important.

In 1952 Crile<sup>5</sup> suggested the use of ACTH or cortisone, reporting an immediate relief of tenderness in from 2 to 3 days with a striking reduction in the size of the thyroid, but with recurrence after short courses of therapy. Clark, Nelson, and Raiman<sup>6</sup> reported three cases diagnosed clinically who were treated with 25 mgm of cortisone orally per day for 14 days. Within 7 days after the initiation of therapy the patients were clinically recovered. Teitelman and Rosenberg<sup>7</sup> reported a single case with dramatic relief, but with relapse because therapy was only carried out for 4 days. Cortisone in 100 mgm doses orally was then administered for 12 days with cure being effected. Lasser<sup>8</sup> reported a case



with complete disappearance of pain in 2½ days and the gland was normal in size at the end of one week as a result of 100 mgm of cortisone daily by injection. When the dose was reduced to 50 mgm daily, reactivation occurred, but an increase in dose was effective. Treatment was carried out for 26 days. Kinsell<sup>9</sup> reported two cases of acute thyroiditis, one of whom had severe exophthalmos and received intensive ACTH or cortisone therapy. In both patients the evidence of acute inflammatory involvement of the gland subsided promptly. Exophthalmos, which was severe enough to consider operative interference, decreased markedly, but the continued administration of ACTH or cortisone was necessary to prevent its recurrence.

Aside from thyroiditis, Kinsell, Partridge, and Foreman<sup>10</sup> have treated nine cases of malignant exophthalmos successfully. Treatment was carried out for 8 months or longer, utilizing ACTH intravenously, ACTH gel, cortisone orally, and maintaining some cases on local cortisone in the eye. A decrease of the exophthalmos occurred in 48 hours. Thyrotropic exophthalmos is caused by thyrotropin *per se*, or by some material of pituitary origin intimately associated with thyrotropin. The local pathology consists of retrobulbar accumulation of tissue in which mononuclear cells, mast cells, and fat may be prominent, and of mononuclear cell infiltration and fibroblastic proliferation in the extra-ocular muscles. The adrenal steroids exercise a lytic effect upon the mononuclear cell, and the hypothesis is that a sufficient amount of corticotropin and related steroids would inhibit thyrotropin production. It appears to eliminate the need for decompression surgery of the orbit in patients with exophthalmos of sufficiently severe degree to endanger survival of the eyes.

Traut<sup>11</sup> described a severe case of rheumatoid arthritis who developed a nodular enlargement of the thyroid while under treatment with cortisone. Radioactive iodine uptake was 35 percent and the swelling became semi-fluctuant. This case would appear to be a true suppurative or bacterial thyroiditis with an entirely different pathological process.

#### Case No. 8

A 48 year old white male complained of tenderness in the base of the neck anteriorly

for three weeks prior to examination on June 23, 1952. There were no preceding respiratory symptoms. For two weeks the diagnosis was in doubt, but then the thyroid gland became palpable and tender. A Silverman needle biopsy confirmed the diagnosis of subacute thyroiditis. Six x-ray treatments, with a total of 800 roentgen units, were given over a period of two weeks. The gland became slightly larger and remained just as tender. He then developed chills with a nightly fever of 102 to 104 degrees, with worsening of the pain in the neck and headache. Cortisone, in 100 mgm oral daily doses, was administered. The pain and systemic symptoms were controlled in 48 hours. The size of the gland regressed somewhat more slowly.

#### Case No. 9

The patient was a 45 year old female who was first seen on April 17, 1953, because of a sore throat. Dysphagia was present, with pain at the base of the neck. Within 24 hours after the onset, a mass could be easily seen, which was tender. Cortisone in a dose of 100 mgm daily was given for 12 days with a lessening of the tenderness and swelling in 3 days. X-ray therapy was also given concurrently with a total dose of 500 roentgen units. An exacerbation of symptoms occurred 5 days after the conclusion of hormone treatment. Cortisone was again given in the same dose for 3 days, when she voluntarily discontinued treatment upon the advice of a neighbor. Forty days after the onset the gland was still slightly tender.

#### Case No. 10

Symptoms had been present for one week when this 34 year old white female was first examined on July 16, 1953. The patient complained of a sore throat and cough occurring in paroxysms due to an irritation at the level of the suprasternal notch. The throat was normal, but the thyroid was enlarged and tender. It was symmetrically enlarged and tender bilaterally, although more tenderness was present on the right than on the left. The estimated weight was 50 grams. The patient was given 50 mgm of cortisone four times a day for three days with a very prompt relief

of the soreness. The cortisone dosage was cut to 25 mgm four times a day, although the thyroid was still definitely palpable at the time of the reduction of the dose. One week after the institution of therapy, the thyroid gland was nontender. However, the thyroid was still enlarged at that time, being reduced about one-third in size.

### DISCUSSION

ACTH and the adrenal steroid hormones provide a non-specific means of controlling, at least temporarily, many metabolic, inflammatory, and allergic disorders. One indication is for the treatment of certain acute self-limited disorders. Thereby, discomfort and disability may be relieved by the administration of suppressive doses of ACTH or cortisone during the natural course of the disease. Short-term therapy of two weeks or less can be carried out safely under a proper regimen without extensive laboratory control. These hormones have been repeatedly demonstrated to suppress inflammatory reactions. A means is provided of rapidly bringing severe pain under control and of arresting the progress of the disease in the thyroid gland. Their use seemed reasonable where other measures are less satisfactory or have failed.

### SUMMARY

These 10 cases of thyroiditis illustrate the clinical characteristics of the disease. Prostration, pain, chills, fever of a cyclic nature, and swelling of the thyroid gland, which is frequently migratory, are the prominent features. Slow, spontaneous recovery after a period of months is the rule in untreated cases. A scientific basis for the use of the adrenal cortical hormones in treating this disease has been outlined. This series, as presented, would substantiate the suc-

cess of treatment of acute thyroiditis by ACTH or cortisone.

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# LIMITATIONS OF CORTISONE AND CORTICOTROPIN IN DERMATOLOGY

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**F**IVE YEARS HAVE ELAPSED since cortisone and corticotropin were first used in the treatment of cutaneous diseases, and during this time some of their real values and many of their limitations have been recognized.

## GENERAL CONSIDERATIONS

The first skin conditions we treated with these agents were psoriasis and lupus erythematosus,<sup>1-3</sup> and subsequently most of the dermatoses for which there is no specific treatment were given a trial of one or the other of these hormones. As so frequently happens, the first patients treated showed improvement, but as therapeutic experience with the steroids increased, enthusiasm for them decreased, so that today it is quite well established that cortisone and corticotropin do not cure patients with cutaneous disease.<sup>4</sup> However, there are a few diseases of the acute type in which the patient is made more comfortable during the attack, and in some fatal diseases, such as acute systemic lupus erythematosus and pemphigus, the patient's life may be extended for variable periods.

During the time that these facts were being accumulated, the physiologic effects of cortisone and corticotropin were recognized as being of great importance, because the results of the action of the hormones might not only be more serious and more far-reaching than the disease under treatment, but they even might be fatal. Although these reactions, serious as they might be, have been discussed and warned against,<sup>5</sup> these drugs have been used freely and inadvisedly in patients with all types of cutaneous diseases, most of which are of a mild nature, run

a self-limited course, and leave no sequelae. "Shooting sparrows with a cannon" may be one way of expressing the enthusiasm with which cortisone and ACTH have been used in the treatment of many of these comparatively mild dermatoses, and it is the purpose of this discussion to point out once again the things that these drugs may be expected to do, not only in the treatment of cutaneous diseases but also the serious or fatal side effects that may develop from their use. In the majority of patients, the prolonged use or the administration of excessive doses of these drugs may produce the undesirable side effects which, however, tend to disappear when the treatment is discontinued. It is to be remembered, nevertheless, that the unfavorable sequelae may appear six months after the use of the drug is stopped, and this delayed reaction time may be serious. Salassa and associates<sup>6</sup> recently have emphasized the fact that if a patient has been receiving one of the steroids and its use is discontinued, and the patient then is found to require a surgical procedure for some condition unrelated to that for which the steroid originally was given, it is necessary to give the cortisone and corticotropin again before and after the operation. Several patients who died after surgery, after taking cortisone several months previously, were found to have pronounced atrophy of the adrenal glands.

Hence, anyone who has received cortisone or corticotropin within six months prior to a contemplated operation and who is to undergo the trauma of surgery, or who has sustained an accident within that period, should immediately be given one or the other of the steroids again. It has even been suggested that patients who have had treatment with either drug carry a card indicating the fact that they have had such treatment, and the amount of the drug given, so that

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in case of an emergency, steroid treatment may be resumed without delay.

The clinical signs of depression of the adrenal cortical function are not numerous or pronounced. The outstanding indications are weakness, fatigue and a decrease in blood pressure. Nausea and mental depression also may develop, and these may appear after use of the drug has been stopped, may persist for varying periods, and are not dependent on the dose of the drug or the length of time it was given. A decrease in the excretion of the 17-ketosteroids is now used by some investigators as a test for adrenal function. Suppression of adrenal function is not dependent on dosage, because any amount which equals or exceeds the daily requirement of 20 mg. a day may suppress the endogenous function of the adrenal cortex. Fortunately, there are marked differences in individuals' reactions to both drugs. The ill effects may be the same from cortisone or ACTH.

The physiological effects of the steroids have been recorded frequently, but are important enough to warrant restating. Although the details of the mechanism of their action are not completely understood, it is now accepted that the administration of cortisone or corticotropin suppresses the secretion of endogenous adrenocorticotrophic hormone by the anterior lobe of the pituitary body. In addition to the unfavorable side effects as noted in the skin, namely, increased pigmentation, hirsutism or alopecia, seborrhea-like dermatitis, acne, atrophic striae, and the "moonface" of Cushing's syndrome, it is necessary to bear in mind that cerebral disturbances such as euphoria, depressed states, frank psychosis, convulsive attacks and changes in personality may develop. In addition, alterations in the electrolyte metabolism resulting in retention of salt and water associated with edema and gain in weight may require adjustment of the intake of sodium chloride and potassium. The transient hyperglycemia usually disappears when administration of the drug is stopped, although the hypertension that develops may persist and be serious. Intercurrent infections, such as tuberculosis, peritonitis, streptococcal and staphylococcal infections and influenza may be masked by the administration of these drugs and accordingly may be overlooked.

Gastric and duodenal activity, also irregular menses and decrease in libido, may be noted, and

local urticarial reactions and anaphylactic shock may follow the intramuscular injection of corticotropin. Teicher and Nelson<sup>7</sup> called attention to the appearance of osteoporosis in cases in which cortisone had been administered for a long time. This may be related to a prolonged negative nitrogen balance. Whether or not hypercoagulability of the blood occurs as the result of steroid therapy is not definitely established, for there are those who say it does occur and those who claim it does not. Thrombo-embolic phenomena and thrombophlebitis may occur, but the cause or mechanism of their production is unknown.

The effects of cortisone and corticotropin on the skin are not well understood. Sulzberger and Baer, however, believe the following actions may occur:<sup>8</sup> "The skin temperature tends to become elevated. . . . The delivery of sweat to the surface tends to be increased. . . . The delivery of sebum to the skin surface tends to be diminished. . . . The flow in the peripheral blood capillaries tends to be accelerated. . . . The nonallergic and allergic immediate urticarial response to scratch or intradermal tests appears to remain grossly unaltered or to be but slightly diminished."

In addition to the ill effects already mentioned, the administration of cortisone to patients with dermatologic disease may produce changes in the cutaneous lesions that are confusing and unexplainable at present. Such changes may consist of a replacing of the morphologic features by new clinical signs, such as occur in patients with lupus erythematosus of the chronic or subacute type, with extensive cutaneous lesions, when the lesions of lupus erythematosus are replaced by those of psoriasis. Moreover, patients with extensive generalized dermatitis may be benefited by the first course of cortisone therapy, but when the eruption recurs, the second or third course of the agent may be of little help. In addition, the morphologic features of a dermatosis may be radically changed, so much so that the disease is not recognizable. In certain conditions, such as lichen planus and psoriasis, after treatment with a steroid, the cutaneous lesions may extend rapidly and become completely generalized.

### CONTRAINDICATIONS

The conditions in which cortisone and corticotropin are contraindicated are the following:

heart failure, hypertensive disease, renal insufficiency, psychotic tendencies, duodenal ulcer, tuberculosis and scleroderma in any form.

As I have said, cortisone and corticotropin tend to mask intercurrent infections by their suppressive effect on inflammatory reactions. Accordingly, serious complications may develop and go unnoticed while the patient is under treatment, so that abscesses, peritonitis, septicemia or the spread of active tuberculous lesions should be anticipated during this particular form of therapy. Systemic fungous infections may be disseminated, and also may not be recognized until they are far advanced. If the administration of either drug is discontinued abruptly because of complications, adrenal cortical insufficiency may develop.

The steroids have been used in several diseases with cutaneous signs, but the results have been so variable and controversial that the treatment is not recommended as a routine procedure. I refer to sarcoidosis, lymphoblastoma, scleroderma and acroscleriosis.

Our recent experience in the treatment of the sclerodermas has been so unfavorable that I now believe cortisone is contraindicated in this disease, contrary to an idea expressed previously. Death due to hypertension and renal disease, not a common complication in the acrosclerotic type of scleroderma, has occurred among some patients treated with cortisone. Because the drug is not curative, its use is no longer recommended.

### QUESTIONABLE RESULTS

Numerous diseases have been treated by steroids with questionable results. I refer to atopic eczema, in which the severe pruritus may be modified for varying periods, although remissions are seldom produced by the use of the drug alone. Likewise, Dillaha and Rothman<sup>9</sup> reported that cortisone would produce a regrowth of hair in patients with alopecia areata and alopecia totalis. In my experience in these diseases the hair did regrow, but fell out again when treatment was discontinued and even fell out while some patients were receiving maintenance doses. In other words, cortisone would regrow hair, but the patient was unable to keep it.

Many patients with other types of diseases of the skin also have been treated with cortisone and corticotropin. Among this group there is the

occasional patient with psoriasis or seborrheic dermatitis or eczema who will derive considerable temporary benefit from this treatment. Since the results are variable and unpredictable, and in view of the possible serious sequelae from the use of such steroid therapy, it is recommended that only an occasional patient, and for some special reason, be treated in this manner. In fact, the dermatologic diseases against which these drugs are of no value are too numerous to mention here, for they include most of the diseases of the skin.

More recently, reports<sup>10</sup> on the use of an ointment containing 1 or 2 percent of hydrocortisone acetate have suggested that the preparation is satisfactory for the treatment of pruritus ani and pruritus vulvae, localized neurodermite and other localized pruritic involvements. The effects are temporary and not curative.

### BENEFICIAL EFFECTS

Cortisone and corticotropin are of definite but limited value in the treatment of certain dermatologic diseases. It is now accepted that neither drug is curative, that the results of treatment are unpredictable in the same types of cases, even against conditions reported to respond well to treatment. Accordingly, this therapeutic inconsistency makes treatment a trial-and-error type of procedure. The drugs have been of value in two types of cases: (1) lupus erythematosus of the acute systemic type and pemphigus, and (2) in certain conditions characterized by inflammatory cutaneous reactions and a comparatively mild and self-limited course.

In the first group the results in the treatment of lupus erythematosus are most striking when the disease is severe and fulminating. Results are manifested by a sense of well-being, moderation of symptoms, decrease in arthralgia, and reduction in the edema, especially of the face, and extension of the patient's life. The remissions are variable in degree and duration, and are less responsive to the second and third attacks. Maintenance doses will retain the disease of some patients in remission for longer periods, whereas in others the disease will relapse, while the patient is still receiving relatively large maintenance doses. As yet, none of the patients with systemic lupus erythematosus whom we have treated has been cured by this agent.



When the disease is less severe, the results of treatment are less spectacular, although the patients will "feel better." In the localized or discoid type of the disease, with no evidence of systemic involvement, the steroids are of no benefit. The laboratory findings, which are so significant in lupus erythematosus, are not materially changed by cortisone therapy. For example, the result of the L.E. cell test may be less strongly positive but does not become negative; the sedimentation rate of the erythrocytes remains high, and the leukopenia may be slightly less pronounced. The urinary findings, indicating renal involvement of the glomerulonephritic type, are not materially changed. The temperature may return to normal.

In a patient with severe lupus erythematosus in whom the kidney is badly damaged or the degree of cardiac disease is advanced, or both, neither cortisone nor corticotropin will overcome these fatal complications.

In pemphigus the therapeutic results of these agents also vary, although apparently there are more patients with pemphigus that has remained in remission, with or without maintenance doses of cortisone, for longer periods, than there are patients with other types of cutaneous diseases similarly treated with comparable results. Lever<sup>11</sup> has reported on some patients with pemphigus vulgaris to whom he administered maintenance doses of cortisone for three years without any signs of recurrence, whereas in others, remission persisted without resort to maintenance therapy. My own experience has been less favorable, in that in none of the patients has the disease been arrested. All those for whom a diagnosis of pemphigus was made have died in spite of steroid therapy.

The oral administration of cortisone in doses of 200 mg. per day may be sufficient for patients with systemic lupus erythematosus or pemphigus, although doses of 400 mg. per day may be necessary. In the occasional case, the intramuscular injection of 100 to 150 mg. of corticotropin per day may help produce a remission. The maintenance doses vary in different individuals, and although it is the aim to retain the remission on the smallest dose possible, it is frequently advisable to give 50 to 100 mg. per day for this purpose. When it is decided to discontinue use of the drug, it is recommended that the dose be reduced gradually and not stopped abruptly.

Also, potassium chloride in doses of 1 gm. given three times a day, and ascorbic acid in a dose of 500 mg. per day, are valuable therapeutic adjuncts.

Among the less severe diseases of the skin, characterized by acute inflammatory reactions, in which the steroids may be of value, may be included dermatitis venenata, severe contact dermatitis, drug eruptions, urticaria, angioneurotic edema and erythema multiforme. In the treatment of these conditions, when they have not responded to other measures, cortisone should be administered for two to three days only, in doses of 200 mg. per day or less. Corticotropin may be given slowly by the intravenous route in doses of 25 to 50 mg. per day.

## CONCLUSIONS

Cortisone and corticotropin will not cure patients with diseases of the skin, although the agents will extend the life expectancy among some of those who have acute systemic lupus erythematosus or pemphigus. The remissions produced by treatment are variable and unpredictable, although in a few cases improvement has been maintained for three years. Relapses are less responsive to treatment.

In diseases less serious and characterized by inflammatory reactions, such as urticaria, dermatitis venenata, drug eruptions, and erythema multiforme, treatment with the hormones will shorten the course and make the patient more comfortable while the disease is running its course.

In certain conditions of the nature of psoriasis, seborrheic dermatitis, dermatomyositis and neurodermatitis, temporary improvement will appear after treatment. The benefit, however, is of short duration, the relapses are more severe than the original condition, and the character of the complications the drugs may produce contraindicates their use except under exceptional circumstances. Because the complications from treatment may be much more serious than the cutaneous disease, it is recommended that cortisone and corticotropin be given only after due consideration of both the benefit and ill effects that may develop.

The steroids may affect every system in the body, and their usefulness in dermatology is limited to decreasing the reaction of tissue to injury



and to decreasing allergic and hypersensitivity reactions. Although neither drug is curative, both help in a few dermatologic diseases. Once treatment is started, it is necessary to maintain adequate but not excessive dosage, to discontinue administration of the drug gradually and slowly, and to anticipate the onset of complications during and after treatment.

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#### *An Abstract:*

#### CONTUSION PNEUMONIA

The author presents seven case reports of pneumonia primary type developing within a few hours following non-penetrating injuries to the thorax.

Animal experimentation is quoted showing that such injuries produce bronchial spasm and increase secretion leading to pulmonary atelectasis and that the pneumonia pathologically is identical with ordinary lobar pneumonia rather than post-operative pneumonia. The pneumonia is usually localized at the site of the trauma suggesting that interference with respiratory movements is a factor. Blows to the front and sides of the chest are more likely to produce this result than those to the posterior wall.

Contusion pneumonia should not be diagnosed if there has been a preceding respiratory infection. The cases reported here responded promptly to antibiotic or sulfonamide therapy.

Copleman, Benjamin, Contusion Pneumonia. *J.M. Soc. New Jersey* 128:132, Vol. 51, April 1954.

# PERFORATION OF THE STOMACH IN A NEWBORN DUE TO A CONGENITAL DEFECT

## A Case Report\*

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*P*EPTIC ULCER in the newborn is so rare that it is seen almost exclusively at the autopsy table. The perforation of such an ulcer is even more unique. But, most unusual of all, is the finding of a perforation in the stomach of a newborn, not due to a pre-existing peptic ulcer but rather due to a rent in the wall caused by a congenital defect in the musculature of that area.

So far as I have been able to determine from an investigation of the available literature on the subject, there have been no more than four such cases ever reported.

(The Armed Forces Institute of Pathology in Washington, D. C., examined the slides in this case and substantiated the opinion of Dr. Robert A. Williams, the autopsy surgeon, as to the true nature of the pathology involved. The acting director of the Institute stated that they have no similar cases in their files.)

I feel that such cases as the ones reported by Burnett and Halpert<sup>1</sup> should not be classified in this category, in that the perforation occurred only after marked dilatation of the stomach secondary to pyloric atresia. Even a stomach with completely normal musculature must eventually rupture if the distention becomes great enough.

However, it is likely that the number of these cases of perforation due to muscular defect is greater by far than a check of the reported cases would lead one to believe. I suspect that a substantial portion of the reported perforated peptic ulcer cases in the newborn—and there are quite

a number—are truly on a congenital muscular defect basis rather than on an ulcer basis. The surgeon at the operating table cannot differentiate accurately between the two conditions. Thus, the true nature of the perforation can be established with complete certainty only if the case comes to autopsy. The final diagnosis rests with the man interpreting the post-mortem microscopic sections. At this point it might be wise to remind the operating surgeon that the perforation of an ulcer in an adult will little resemble the same condition in the newborn. In the adult, the perforation is through a thickened, edematous area, but in the newborn the pathology of perforation is superimposed on an acute process, and the typical perforated ulcer appearance of the adult will not be present. So that one may safely say that while the perforation may seem to be through normal or only slightly thinned out wall, only the microscopic sections will reveal if an ulceration was present or whether a musculature defect was the basic cause of the rupture.

Another reason that the number of reported cases is a poor index to the actual incidence of this rarity is that not enough autopsies in the newborn are done. Very likely, some of these newborn cases of intractable vomiting that die and are listed under "death due to cerebral hemorrhage"—truly have a perforation of the stomach as the real cause of death.

To Herrbut<sup>2</sup> in 1943 must go the credit for the first reported case of a perforation of the stomach due to congenital musculature defect. He presented adequate microscopic material to support his case. Potter<sup>3</sup> in 1952 has another similar case to report. The patients in both these

\* Presented at staff meeting of Porter Memorial Hospital, Porter County, Indiana, August 1953.

cases died and the microscopic sections of the defects were available.

In 1951, Ross, Hill and Hass<sup>4</sup> reported a case of stomach perforation in the newborn, and, so far as I know, their patient was the only one in which surgery was done and where the results were completely satisfactory. Their baby came to surgery only 10 hours after the perforation occurred and probably the short time factor, plus the greater use of antibiotics, etc., brought this child through the surgery successfully, while other less fortunate infants died.

### REPORT OF A CASE

The child was born April 1, 1953; it was a full term, white, male child, weighing 8½ lbs. The birth followed a normal prenatal period and an uncomplicated labor and delivery in a healthy multipara. It was accomplished by low forceps with the mother under full anesthesia. This is mentioned so that the possibility of a traumatic rupture of a viscus having occurred during the birth, may be eliminated. The child was examined before it left the delivery room and was sent to the nursery under the impression that it was a healthy child. The first two days of life were uneventful. The child took its feedings well and seemed to prosper. Meconium stools were gradually replaced by the usual "milk" stools. On the third day, non-projectile vomiting of a bile stained material started, and the baby retained very little. Phenobarbital and belladonna were started and almost immediately the vomiting stopped. The baby vomited only once on the fourth day and seemed in good health. On the fifth day, vomiting again started and the spells of emesis were more numerous and copious than before. The temperature ranged between normal and 101°. On the sixth day, the vomiting still continued even though nothing had been given by mouth for the previous 24 hours. Quite suddenly on the seventh day, the baby seemed much worse. Cyanosis and toxemia seemed to increase by the hour, in spite of continuous supportive therapy, including parenteral fluids, antibiotics, oxygen, etc. Portable x-rays were taken. These included films using a weak suspension of barium as a contrast medium. No visible air was demonstrated under the diaphragm; but this may have been because no exposures were made with the child in the

upright position. The diagnosis of perforation of the stomach was obvious in that the barium quickly spilled out of the stomach into the left gutter and within 20-minutes had collected around the rectal ampulla. The X-ray film shown here was taken 20-minutes after the barium was put into the stomach—note spillage of barium into the lateral gutter. The baby died on the seventh day.

An autopsy was done; the significant portion of the report reads as follows:

1. Congenital muscular defect in the stomach with the resulting perforation of the fundus of the stomach. The accompanying slide shows the normal portion of the stomach wall (to the right) as compared with the portion of the stomach wall deficient in the muscular layer (to the left).

2. Generalized peritonitis.

### COMMENT

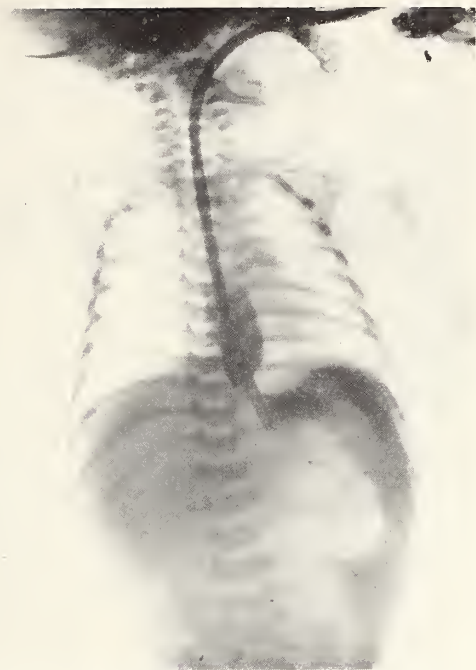
Several aspects of this case deserve mentioning:

1. Though the red count was normal, the white count was unusually and unexpectedly low, being only 4,000. In a surprising number of peritonitis cases in infants, the white count is low. The best explanation is very likely the poor resistance of the child to an overwhelming infection and toxemia.

2. Distention was never a marked feature in this case. Contrary to the usual conception of peritonitis, the abdomen of this baby, while not flat, yet was not distended particularly—and at all times seemed not rigid but rather soft! The most characteristic thing about the abdomen during this period was the prominence of the veins of the abdominal wall. This is one important point the significance of which, in the diagnosis of peritonitis in the newborn, cannot be discounted.

3. The use of even a weak suspension of barium passed through a gavage tube, might be questioned. The procedure was done on this child only when it was obvious that the child would die very shortly; hence, it was felt that this would not appreciably influence the child's chances of survival. A preferable procedure might have been to use lipiodol, or, even better,



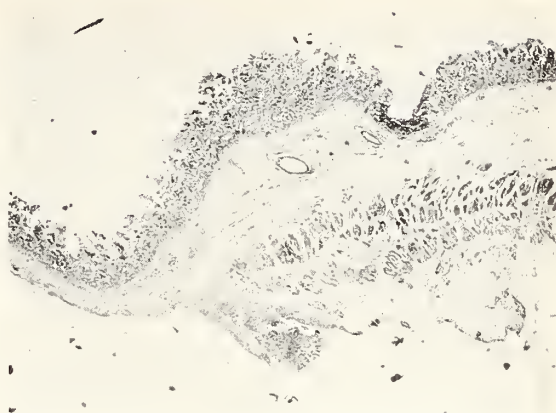


X-ray taken 20 minutes after barium was placed in stomach.

a preparation such as diodrast which is free-flowing and can be handled so much more easily than the heavy oils like lipiodol, etc. Should this material enter into the peritoneal cavity, it is unlikely to cause either a chemical irritation or result in iodine poisoning. It should be stressed here that any child sick enough to be suspected of having a bowel obstruction, perforation of a viscus, or peritonitis from any cause, deserves pictures taken in the vertical, as well as the horizontal position.

#### SUMMARY AND CONCLUSION

1. A case report with pertinent autopsy findings is presented of a perforation of the stomach



A.F.I.P. Photo No. 53-18678 X 21½. Cross-section of stomach wall adjacent to defect. Note how the muscularis layer completely fades out as it approaches the perforation site.

of the newborn based on a congenital focal defect in the musculature.

2. The early search for free air under the diaphragm should always be made in the acutely ill newborn child.

3. The greater use of diodrast should be encouraged to help one arrive at the correct diagnosis earlier in cases of vomiting of obscure origin in the newborn.

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# The *Journal*

of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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## ANNUAL CONVENTION 1954

**P**RELIMINARY ANNOUNCEMENTS are being made for the Annual Convention in Indianapolis next October 24, 25, 26, and 27. The scientific program is well advanced and will be reported in detail in an early issue of THE JOURNAL.

The general planning of the meeting will be along the same lines as were followed last year. October 24 is on Sunday and this day will be utilized for official business, in order to free the officers and delegates for participation in the scientific sessions on later days. The Executive Committee and the Council will meet on Sunday and the first session of the House of Delegates will be held that evening.

Monday will be devoted to meetings of Reference Committees, to the Instructional Courses, and to the sports events and evening smoker.

On Tuesday morning a symposium under the chairmanship of Dr. J. O. Ritchey will consider medical and surgical emergencies, with special speakers on the medical, surgical, pediatric,

orthopedic, anesthetic and general practice aspects of this large subject. Later that morning a special presentation is planned on industrial medical practice.

Tuesday afternoon the newer developments in medicine will be discussed. These will include pentothalcurare and other new anesthetic agents, the radioactive isotopes, the antibiotics and some newer drugs for treatment of hypertension.

The Wednesday morning program will be on medical economic subjects and will include a presentation on legal medicine. Wednesday afternoon will be given over to the section meetings.

Tuesday night will be known as President's Night and will feature the address of President Harry Howard, together with special entertainment. The annual dinner dance will be held on Wednesday night.

Acceptances have not been received from all the guest speakers at the time this is written.

A detailed scientific program will be published later, but well before the time of meeting, to give you the names of the distinguished speakers and their subjects. What promises to be the

largest and best technical exhibit the association has ever attracted is assured. Every member should make plans to attend at least part of this splendid program.

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## PATIENTS WANT FRIENDLINESS AND COMFORT

**D**R. A. E. SEVERINGHAUS, associate dean of the Faculty of Medicine of Columbia University, has received favorable comment in many of the daily newspapers in the state, following a lecture which he delivered at Bloomington on the occasion of the presentation to him of a Distinguished Service Award.

The lecture emphasized that more education in the liberal arts, more postgraduate education in medicine, and possibly less specialization are all needed to produce doctors who will have the same appeal to their patients as did the general practitioners of years gone by.

These things have been said before. What is significant about the lecture was not so much what was said, but how it was received by the newspapers who are writing for the general public. The change in attitude of the public to the practitioners of medicine as a group is one of medicine's problems. It has been discussed considerably; and it is well to continue the discussion, since it touches the vital relationship in the practice itself.

The fact that the subject recurs in the public press would indicate that the problem has not been solved, at least not completely solved. The fact that the subject is often discussed without rancor, and that its solution is sought by laymen and physicians alike, with sincerity and earnestness, indicates that it is still a real problem.

The "beloved general practitioner of yesterday" was friendly, sympathetic and understanding. He spent much more time with the patient and with the family than does his modern counterpart. One reason why these attributes were so highly developed in the olden days, and why

they play such a large part in peoples' remembrances, is that in many instances they were almost the only thing the doctor had to offer the sick patient.

The development of diagnostic tests has tended to reduce the time which the doctor spends with a patient. The advent of a multitude of specific drugs has tended to increase the physician's confidence in a cure and thereby has tended to reduce the amount of reassurance which he feels is necessary. When medicine becomes more exact and more curative it tends to become more impersonal, although there is no reason why it necessarily must do so.

It is well to remember that the primary object of a patient's visit to a doctor is not to achieve a cure, but to obtain friendship, reassurance and understanding. Patients and their relatives come to have their fears and apprehensions calmed. They are more deeply concerned with this part of the doctor-patient relationship than with the more scientific and curative elements.

Sir Hugh Cairns once wrote of this problem—"Your patients need from you more than diagnostic and therapeutic efficiency. They do not come to you to be cured; they come to be relieved of their pain and other symptoms and to be comforted. Given the choice they would usually prefer a kind doctor to an efficient one."

Often the most grateful patient is the incurable one; the patient for whom we can do very little in way of curative or even palliative treatment, but who values what little can be done for him in the form of comfort and understanding much more, it seems, than other patients value a cure.

It may be that more education and less specialization is not the answer to the problem. Per-



haps the affection that existed between the old-fashioned doctor and his patient could be achieved by all of us, if we keep reminding ourselves that the understanding and sympathy

which the old doctor brought to the sick room, is just as necessary today, even though we bring also a much more exact and efficient and scientific type of medical practice.

## THE VA's TIME OF DECISION IS NOW

**T**HE MEDICAL SCHOOLS of the country have developed a tremendous stake in the 85 Veterans Administration hospitals in which they have established a Dean's Committee relationship since World War II.

This relationship has been advantageous to all concerned: it has helped the VA attract much better qualified medical men and thereby raised the standard of medical care provided; it has made increased numbers of teaching beds and well qualified clinicians in charge of those beds available to neighboring medical schools, and thus has strengthened their teaching program.

Two important facts, however, have given the medical schools reason to pause and take stock of this cooperative venture. The *first* fact is that new VA hospitals have been and still are being built at an alarming rate. There were 71 in 1934, there will be 174 of them by June of this year. This year's addition alone consists of 11 hospitals. The *second* fact is that though those setting up the original legislation intended that VA hospitals should be primarily for the care of those wounded or made ill in the service of their country, at least 52 per cent of the present patient load in our VA hospitals consists of veterans whose ailments are completely unconnected with war or military service, and approximately 85 per cent of a typical year's admissions are for nonservice-connected disabilities.

For these latter facts, VA officials blame Congress and loose legislation governing VA hospital admission. The Congress in turn has assumed that because the spokesmen of the American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, and the

American Veterans of World War II, favored free care of veterans for civilian (nonservice-connected) disability that they were speaking for the 20,200,000 ex-service men. That these organizations do not in fact fairly represent the thinking of our ex-service men in this matter is shown by a poll of veterans carried out in 48 states by George Gallup and the American Institute of Public Opinion. As recently reported, 52 per cent of the veterans polled were opposed to free care of veterans suffering from civilian illnesses.

It is obvious that unless the present inordinate growth of VA hospitals is stopped and veterans with nonservice-connected disabilities excluded from care except in cases of thoroughly investigated and proven cases of indigency, the country will be taken down the road to government medicine via the VA route just as certainly as if it followed the national compulsory medical care insurance route. Our medical schools do not want to see this occur, much less give it their assistance and blessing.

The VA, therefore, stands at the fork of the road. New regulations are going into force relating to the admission of veterans with nonservice-connected disabilities. In making his application for admission the veteran must henceforth list his assets as well as his liabilities. The medical schools will be vigilantly watching how this new regulation is made to work. If it is made to work well, the future of the relationship between the VA and the medical schools looks bright. If the new regulation is not honored and not followed up, the outlook is dark indeed. It is for the VA to make its decision.

—D.F.S.

—The Journal of Medical Education.

## THE PSYCHOLOGY OF MULTIPLE SCLEROSIS

THOSE TAXES which have caused such a severe and dangerous cachexia of personal savings have, on the other hand, stimulated the growth and flowering of tax-free foundations, societies, and funds. Amongst the assiduous cultivators of these organisms the executive secretary must rank high. H. L. Mencken said, in "The Executive Secretary," "Once three or four—or maybe even only one or two—easy marks with sound bank accounts have been snared, the new national—or perhaps it is international—association is on its legs, and all that remains is to have brilliant stationery printed, put in a slightly stenographer, and begin deluging bishops, editors, and the gullible generally with literature. The executive secretary, if he has any literary passion in him, may prepare this literature himself, but more often he employs experts to do it."<sup>1</sup>

This office received recently, from the National Multiple Sclerosis Society, a booklet of 34 pages, entitled *Psychological Factors in the Care of Patients with Multiple Sclerosis*, prepared under a grant from that society, by Molly R. Harrower, Ph.D., and Rosalind Herrmann, B.A. This is a relatively restrained piece of the

publisher's art, for it contains no coloured abstractions by contemporary artists, as do so many outpourings of these organizations devoted to spending the incomes and resources of foundations and societies. It contains a brief review of the pertinent literature—60 titles in the bibliography—and some valuable observations on the art of medical practice. The cloud of psychological obscurantism is thin, and readily penetrated by a practitioner.

One noteworthy feature of the book is that the senior author, Molly Harrower, Ph.D., urges apparently, that psychologists be recognized as competent, independently, to diagnose and administer psychotherapy to the patient with multiple sclerosis. We wonder about the medical practice act of that state where she holds forth.

Another interesting bit of ingenuity is shown in putting a "clinic medical social research worker" and a "group work student" each in charge of a group for group-therapy for relatives. Has this psychologist succeeded wherein so many physicians have failed—in keeping the relatives out of his hair?

We have found this a stimulating book, but fear that our response would be classified, by M. R. Harrower, as aberrant from the one she hoped to obtain.

—*Northwest Medicine*, March, 1954.

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### 1892 MEDICAL GLOSSARY ADDED TO I.S.M.A. ARCHIVES

"Medical students and practitioners often have need of a small, elementary word-book that may be slipped into the pocket for hurried reference and to serve as a passing reminder of the essential meanings of the more commonly used terms. . . ."

That was the first sentence in the preface to "12000 MEDICAL WORDS, Pronounced and Defined," published in 1892 at Philadelphia by P. Blakiston, Son & Co. The author was George M. Gould, A.M., M.D.

A copy of the little handbook has been added to the archives at Indiana State Medical Association headquarters through the thoughtfulness of LeRoy J. Badollet, executive assistant, Indianapolis Power & Light Company. The book was used by his grandfather, Dr. Henry W. Held, Vincennes, practicing physician and member of the Indiana State Medical Society for a number of years. Its leather binding and gilt-edged pages show signs of steady, careful use.

# The President's Page

FELLOW MEMBERS OF I.S.M.A.:

HERE it is June: Nearly every District has held or will hold their Councilor District Meeting in May and June. The Secretary, President-elect and President try to attend these meetings and make a report on what the State Association is doing. When there are as many as five meetings in one day this is difficult, and when the meetings are scattered it is impossible. If all of us are unable to attend it is not because we did not wish to do so. There should be some way these meetings could be staggered throughout the spring months.

While we are on the subject of Councilor Districts, some of us have felt that it might be a good idea to have nominations for the Board of Directors of Blue Shield made from each Councilor District. At present these nominations are made by the State Council. If you do not wish to change the latter method, at least the District could inform the Council of its choice of a Director to represent their district. We have no fault to find with our present Directors but feel this method would tie Blue Shield closer to the grass roots in this State.

At the last Council Meeting it was suggested that state committees be appointed for three years with one-third being appointed each year. This would give more continuity to the Committees and cut the load on the incoming President.

The Public Relations Committee, of which Dr. Earl Mericle is chairman, has their new Public Relations program in full swing. Have you heard any of their radio spot announcements? Later there will be some television shorts. This program will cover 13 weeks. This should help bring the story of Indiana medicine to a goodly number of people.

The senior class in medicine together with their wives and guests were given a dinner by the Rural Health Committee of which Doctor J. E. Dudding is the chairman. The entire committee attended and together with some of the recent graduates painted such a glowing future of the advantages of rural practice that some of us in the cities felt we might have missed the boat in not going into rural practice.

The American Medical Association meeting is in San Francisco the last of June, followed by a trip to Hawaii. You might join the other 50 or 75 Indiana doctors and give your wife a break. I think you would enjoy seeing her dance in a grass skirt on the beach at Waikiki.

*Wm. Harry Howard M.D.*



## POLIO IN INDIANA—JANUARY 1 THROUGH SEPTEMBER 26, 1953\*

ALBERT L. MARSHALL, JR., M.D.

*Indianapolis*

INDIANA has passed through another polio season. Although the final reports for the year are not in, sufficient information is available to indicate that the Hoosier state has been very fortunate this year. For the week ending September 26 a total of 516 cases have been officially reported to the Indiana State Board of Health. The statisticians inform us that judging from past experience in Indiana 61.5% of the year's total number of cases have been reported by this time. Provided the statisticians are correct, Indiana should have approximately only 900 cases for all of 1953.

The 516 cases reported to date have been fairly well distributed over the state. Case rates (number of cases per 100,000 population) and critical rates (case rate calculated from estimated number of cases) have been calculated for each county weekly. A close watch has been kept on the counties with large numbers of cases reported in comparison to their population. At no time have any of these counties been dangerously near the critical rate required to qualify the county for mass immunization with Gamma Globulin (the critical rates have been established weekly by the Office of Defense Mobilization).

Those cases reported only as "poliomyelitis" have been grouped under "unspecified" in the accompanying table. All cases are investigated by a questionnaire being mailed to the physician reporting the case. The willing cooperation of Hoosier doctors has made possible the breakdown of reported cases here presented and is sincerely appreciated. Letters are in the mail

at the present time concerning the "unspecified" cases in the present report, so that when the report is completed it is expected to find very few or any cases in this category. The complete reporting of any one case is of little significance, however when they are combined it provides a wealth of material for the health officer and the individual practitioner. Such information tells at a glance the concentration of the disease by county, the severity of the disease during the year, and the incidence by sex and age.

The expected incidence of polio in Indiana is 30 cases per 100,000 population. At the present time Indiana's case rate is 13 per 100,000 and probably will not exceed 22 per 100,000 for the year. The expected mortality rate is 8% of the reported cases. With 516 reported cases and 20 deaths, Indiana's mortality rate is about 4%.

From the preceding, it is readily seen that we have been fortunate in the decreased number of cases of polio that we might normally expect, as well as the fact that the disease in Indiana has manifested itself more mildly than it has formerly. These facts coupled with the understanding and cooperation of the physicians have lessened the problems attendant with the administration of the distribution of immune serum globulin for poliomyelitis prophylaxis. With the limited supply furnished the state it was feared it would soon be depleted. At the present time approximately 2200 polio contacts have been given the globulin. Questionnaires are being mailed to the physicians who administered the globulin to determine if anyone receiving it subsequently developed poliomyelitis. From the replies received to date, only one case of polio has been found occurring in an individ-

(Please turn to Page 630)

\* This paper was presented at the annual meeting of the Indiana State Medical Association at French Lick, October, 1953. Doctor Marshall is Director of the Division of Communicable Disease Control, Indiana State Board of Health.

## Senior Class Day Speakers . . .

Program headliners for the first Senior Class Day, sponsored by the Committee on Rural Health of the ISMA, include left to right and from top to bottom: Dr. Joseph Dudding, chairman; Mrs. Charles Sewell and Dr. Wm. Harry Howard; Mrs. D. E. Lybrook and Dr. Bert Ellis; Mrs. Robert Seibel; Dr. Eli Goodman; Dr. William Paynter; Dr. W. L. Porteus; Mrs. H. C. Harvey; Pierre de Tarnowsky.





## Tell I. U. Medical Students of Practice in Rural Indiana

"The Practice of Medicine—What Is It Like?"—the theme for the program of the Senior Class Day for Indiana University medical students and their wives—was treated from all angles by speakers whose personal experiences formed background material for their talks.

Arranged by the Committee on Rural Health of the Indiana State Medical Association, the May 1 meeting in the Columbia Club, Indianapolis, was a successful experiment. Plans are now under way to hold similar orientation and social programs for each graduating class from I.U. School of Medicine.

Senior students and their wives were given a panoramic view of the practice of medicine in Indiana—with emphasis on the wisdom of establishing practice and home in small towns or even strictly rural areas.

Dr. Bert E. Ellis, Indianapolis, was toastmaster. Friendly and amusing, he established quick liaison between speakers and audience.

Greetings were extended by Dr. Wm. Harry Howard, Hammond, president of Indiana State Medical Association; Dr. William Paynter, Pekin (Class of 1952), told of "The Mechanics of Setting Up a Practice"; Mrs. Robert Seibel, Nashville, described graphically her life as the wife of a small town doctor in "With Your Apron On or Off"; Dr. Eli Goodman, Charlestown, had a triple title to his talk on the advantages of small towns. He called it "Gasoline Fumes or Fresh Air—Urban vs. Rural Practice—or, Chicago versus Charlestown."

Dr. Joseph Dudding, Hope, said "It Always Shows—You Can't Hide Your Public Relations" and then spoke of the warmth and friendliness of Indiana's rural communities where the family physician is frequently called "Doc" or "Joe" and likes it.

"What Is Organized Medicine" was discussed by James A. Waggener, Franklin, ISMA execu-

(Continued on Page 648)

Medical students and their wives listen attentively as the story of the practice of medicine is told.





## Polio—Continued

ual receiving GG. This single case was a pregnant female who developed paralysis of a lower extremity two days after receiving the globulin. Inasmuch as it has been shown that no protection is afforded during the first week following injection of gamma globulin, we can only conjecture that she received it too late, or else that having received the gamma globulin her paralysis was not as severe as it might have been.

A comparison of the cases reported as of September 26, 1953 and the corresponding periods for the four preceding years:

Year	Number of Cases	Number of Deaths
1953-----	516	20
1952-----	898	22
1951-----	264	20
1950-----	311	23
1949-----	897	77

A heartening note as to the validity of the present figures and the prediction of only 900 cases for Indiana for 1953 is justified.\* In former years the number of individuals seeking aid from the National Foundation for Infantile Paralysis and the cases officially reported have been at wide variance. This year the figure of the volunteer agency and the State Board of Health are running extremely close. This is an indication of the excellent reporting of this disease this year by the physicians and health officers of the state.

The accompanying table will provide interesting material concerning the cases that occurred in each county.

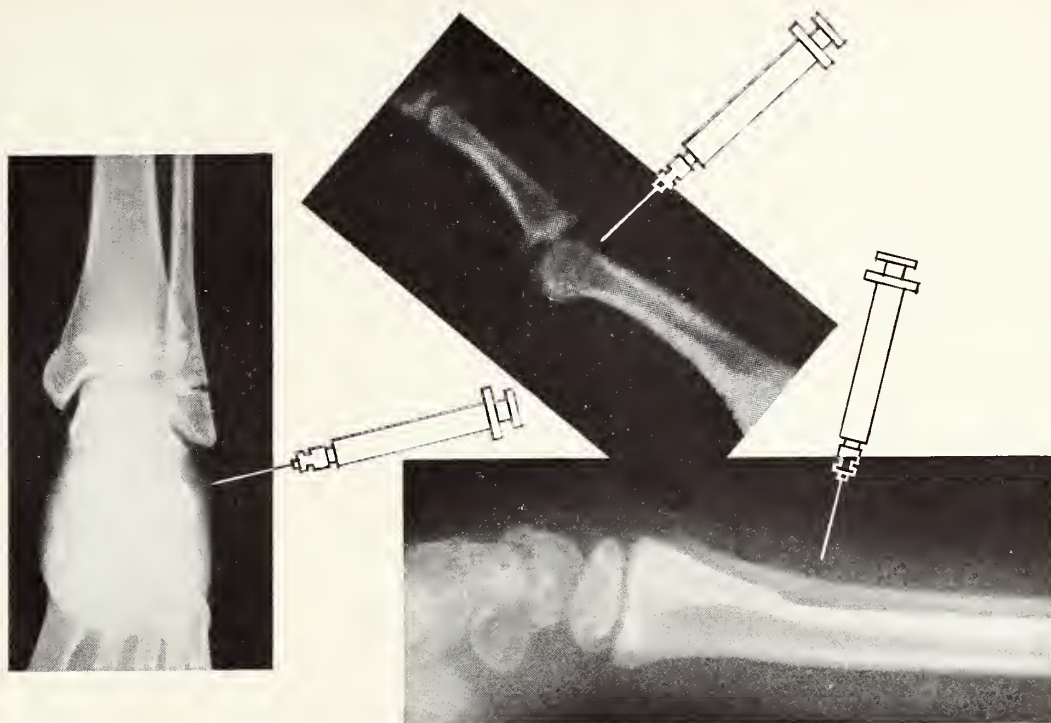
1953 Poliomyelitis Cases Reported to Date,  
by County and Type September 26, 1953

County	Total Cases	Abortive	Non-Paralytic	Paralytic	Bulbar	Unspec.*
Adams -----	1			1		
Allen -----	32	1	10	14	7	
Bartholomew ---	3			1		2
Benton -----	1			1		
Blackford -----	3		2	1		
Brown -----	1					1

\* 625 diagnosed cases of poliomyelitis and 31 deaths from the disease were reported for 1953 calendar year.

County	Total Cases	Abortive	Non-Paralytic	Paralytic	Bulbar	Unspec.*
Clark -----	8	1	2	2		3
Clay -----	2		1		1	
Clinton -----	2				1	1
Dearborn -----	3	1	1	1		
Decatur -----	1	1				
Dekalb -----	12	1	5	4	2	
Delaware -----	27	2	8	16	1	
Dubois -----	1			1		
Elkhart -----	31		12	11	1	7
Fayette -----	1		1			
Fountain -----	1		1			
Franklin -----	2		1	1		
Fulton -----	2			2		
Gibson -----	12		2	6		4
Grant -----	6		4	2		
Hamilton -----	4			3	1	
Harrison -----	5		2	1		2
Hendricks -----	8	1	4	3		
Henry -----	1				1	
Howard -----	10		2	2	3	3
Huntington -----	4	1	1	1	1	
Jackson -----	3				1	2
Jasper -----	1				1	
Jay -----	2		1	1		
Jefferson -----	1					1
Jennings -----	1			1		
Johnson -----	6		4	2		
Knox -----	2		1	1		
Kosciusko -----	6		4	2		
Lagrange -----	8	1	2	3	1	1
Lake -----	38	2	11	11	8	6
Laporte -----	11		4	3	3	1
Lawrence -----	2			2		
Madison -----	6		4	1		1
Marion -----	41	2	9	16	8	6
Marshall -----	8		2	2		4
Miami -----	1			1		
Monroe -----	4			3		1
Montgomery -----	7		2	3		2
Morgan -----	1	1				
Noble -----	4		2	2		
Orange -----	2			1	1	
Owen -----	1			1		
Parke -----	1			1		
Perry -----	5		2	2		1
Porter -----	10	1	6	2		1
Posey -----	3		2	1		
St. Joseph -----	48	3	28	7	1	9
Scott -----	2			2		
Spencer -----	5		3	1		1
Starke -----	1		1			
Steuben -----	5		1	2	2	
Tippecanoe -----	1		1			
Tipton -----	1				1	
Union -----	1		1			
Vanderburgh -----	52		21	26	4	1
Vermillion -----	1			1		
Vigo -----	13		4	8		1
Wabash -----	4	1		3		
Warwick -----	2		1	1		
Wayne -----	14	2	5	4	1	2
Wells -----	2				2	
White -----	5		1	3	1	
Indiana -----	516	22	182	194	54	64

\* Unspecified



## Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery<sup>1</sup> where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means<sup>1, 2</sup> of accelerating dispersion of accumulated fluids.*

Swenson<sup>2</sup> has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anes-

thesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.



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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

## THE MONTH IN WASHINGTON

WASHINGTON, D. C.—At the request of the Defense Department, Congress is considering a bill to expand and make more uniform the medical care program for civilian dependents of military personnel. It could have significant impact on the practice of medicine and on medical economics.

The legislation developed out of the Defense Department's Moulton Commission report of a year ago. In the intervening months the department's legislative planners called in representatives of the American Medical Association and other professional groups for advice. But the bill finally presented to Congress is evidence that not all differences of opinion were compromised. While in many respects the measure is in line with the policy of AMA on dependent care, at least one basic conflict remains:

The department's bill states that dependents should receive private medical care only when military facilities are unavailable or inadequate. The AMA's policy, adopted after long study of the problem, is that dependents should be cared for in military hospitals and by uniformed physicians only when civilian care is inadequate or unavailable.

There is almost complete agreement that the present patchwork dependent medical care program should be changed to make benefits uniform geographically and within the services, and to spell out the benefits in law. The issue is whether the military medical services should care for all qualified civilian dependents, or dependents should, like the rest of the population, get their medical care from civilian physicians and hospitals.

Under the bill, medical care furnished by or underwritten by the federal government would be limited to "diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity and infant care." Dental care

would be allowed only in emergencies or as an adjunct to medical care. These restrictions would be waived overseas and at remote stations in the United States.

The definition of "dependents" would not extend beyond parents and parents-in-law, and these relatives would have to receive at least half their support from the military member to qualify.

The Secretary of Defense would decide what charges, if any, to levy against dependents treated at military facilities. When treated privately, the dependents would pay the first \$10 cost of any illness, plus not more than 10% of the total cost. The secretary could make use of voluntary health insurance for dependents if this system were found to be more economical.

The Senate Armed Services Committee was slow to take up the dependent care bill because of a heavy schedule of other hearings. Nor did it make fast progress in the House. There the introduction of the bill was delayed when Chairman Dewey Short (R., Mo.) called on Defense Department to furnish him with detailed information on what the new medical care program would cost.

By mid-May, when Congress had about concluded hearings on all major administration health bills, a new factor was introduced. Chairman Wolverton of the House Interstate and Foreign Commerce Committee called hearings on his own bill for federal guarantee of private loans to health facilities. This was not part of the original Eisenhower health program, but there were some indications that the administration might get behind it.

As originally drawn, the bill would virtually exclude all clinics and hospitals except those operated in conjunction with prepaid insurance plans. During the hearings, Mr. Wolverton indicated he would be willing to drop this restriction.

If this were done, the law then would offer benefits to all—fee-for-service physicians and groups as well as “closed panels.”

During this period, some sentiment developed to combine the loan guarantee bill with the reinsurance bill, which wasn't making much progress on its own. The result was a period of confusion and uncertainty, with no clear indication of what either the committee or the administration really wanted.

A few other medically-important bills were advancing on schedule. The House Ways and Means Committee gave every indication of reporting out a bill to require all employers (physicians included) to participate in the federal-state unemployment insurance program. As usual moving faster than the Senate, the House had passed a bill to give state health officers more control over federal grants for public health work. The House also was nearing a vote on extension of the social security program, with no suggestion that physicians and other self-employed groups who don't want coverage would be exempted. The House-approved Hill-Burton expansion bill was waiting action in the Senate.

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, August 9, October 11.

Surgical Anatomy & Clinical Surgery, Two Weeks, June 21, August 23.

Surgery of Colon & Rectum, One Week, September 13.  
Basic Principles in General Surgery, Two Weeks, September 20.  
Breast & Thyroid Surgery, One Week, June 21.  
Thoracic Surgery, One Week, October 11.  
Esophageal Surgery, One Week, October 4.  
General Surgery, Two Weeks, July 26; One Week, October 4.  
Gallbladder Surgery, Ten Hours, October 25.  
Fractures & Traumatic Surgery, Two Weeks, October 25.

**GYNECOLOGY**—Office & Operative Gynecology, Two Weeks, September 20.  
Vaginal Approach to Pelvic Surgery, One Week, June 21.

**MEDICINE**—Two-Week Course, September 27.  
Electrocardiology & Heart Disease, Two Weeks, July 12.  
Gastroenterology, Two Weeks, October 25.

**RADIOLOGY**—Diagnostic Course, Two Weeks, October 4.  
Clinical Course, Two Weeks, by appointment.  
Radiation Therapy, by appointment.

**PEDIATRICS**—Clinical Course, Two Weeks by appointment.  
Congenital & Rheumatic Heart Disease in Infants & Children, One Week, October 11 and October 18.  
Two Weeks, October 11.

**UROLOGY**—Two-Week Urology Course, September 20.  
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## GPs Convene in Indianapolis



Several hundred physicians who specialize in the general practice of medicine throughout Indiana attended the Sixth Annual Scientific Session of the Indiana Academy of General Practice in Indianapolis April 13-15. Informal groups, pictured above, were photographed during the three-day meeting. In the center of the upper left picture is Dr. Alfred C. Kinsey, Indiana University professor and author, who delivered the Founders Lecture on the last evening program.

# THE PHYSICIAN AND THE GRIEVANCE COMMITTEE

JAMES M. LEFFEL, M.D.\*

*Indianapolis*

IT WOULD APPEAR that many doctors think there is a need for grievance committees, for otherwise no time would have been allotted today for a discussion of the same. Few doctors, however, agree on how much such committees are needed. Our leaders have almost routinely lulled us to sleep by telling us what a fine lot we are. We are, by comparison, a fine group; but we have some deficiencies, just as our forefathers had. We must correct these faults, however, since the public, for the first time in history, has been informed of our shortcomings. Committees can help but standing back of our committees must be firm leaders and a united strong society. From the *Irish Digest* came the quotation, "If Moses had been a committee, the Israelites would still be in Egypt". Another definition of committees was expressed by our former local colleague, Dr. Russell R. Hippensteel (where he read this is vague). He said, "A committee consists of a group of men who individually can do nothing: but after discussing a situation, decide there is nothing to be done". Our leaders must insist that our committees function. Further, we must not stand by and observe the disciplining of a few and count ourselves pure; but rather we must admit that we have all made mistakes, that we all must improve, and then standing together see that the job is done.

During the past three years, the Grievance Committee of the Indianapolis Medical Society has at times been firm but often probably too lenient. This committee has been termed for

the past two years the Board of Appeals on Patient-Physician Relationship. The latter more accurately defines the function of such a group and avoids the provocative word "grievance".

The manner in which this group has functioned has been as follows:

1. No verbal complaint has been accepted for study.
2. All written complaints have been acknowledged at once.
3. The complainant has been asked if the doctor involved has been approached by him directly and, if not, this approach has been encouraged.
4. The doctor involved has been notified regarding the complaint and asked to contact the complainant in the hope that the two could settle their differences.
5. When no such direct settlement could be reached, the committee has investigated the matter thoroughly, weighing the complaint against the doctor's statement given the group in person or by letter. The doctor involved always has been invited to appear before the committee.
6. After deliberation, the committee has sent its recommendations to the complainant by letter and sent a copy of the same letter to the involved doctor. A letter with suggestions has been mailed the same day to the involved doctor but, obviously a copy of that letter has not been sent to the complainant.
7. There were a few exceptions made to No. 6, in that at times it appeared wise for the chairman to talk with the complainant

\* Doctor Leffel is chairman of the Board of Appeals on Patient-Physician Relationship of the Indianapolis Medical Society and presented this paper as a part of the program at the annual County Officers Conference in March 7 in the Student Union building at the Indiana University Medical Center.

rather than put the committee's findings in writing.

The cooperation of the doctors in almost all instances has been excellent. Many cases were settled directly by the doctors. When the committee found against doctors, they were very cooperative about making necessary concessions in all but a very few instances. In these very few instances, disciplinary action was taken in one case, in the others nothing was done. Steps should be taken to give such a committee greater power to discipline chronic offenders.

### **"Have I Earned It?"**

The complaint most frequently brought to our attention had to do with fees. In some instances, the fees were too high and almost always the doctor was glad to make an adjustment. We feel that the doctors interviewed regarding fees in the past three years have, for the most part, known deep in their hearts that the charges might be excessive. Why were the charges exacted? It is difficult to know. The only solution we can suggest is that physicians should in arriving at a charge examine their hearts and say to themselves, "Have I earned it?". Then, from a more practical point of view let them consider; could such a bill be honestly defended before a group of my fellow practitioners? It goes without saying that we should not charge so excessively that we should risk our affairs being brought before any committee. The thought of such an adjustment should temper our emotions. We should, we believe, stand together in supporting the decision of a committee and by so doing all be willing to adjust our fees if so suggested. Better by far, we should make just charges. If our objective in the practice of medicine is to make a fortune, we are in the wrong profession and, if any of us persist in the same, we should not be tolerated. We will drop this point with these generalities, for the matter is to be discussed fully by our president, Doctor Howard.

The complaint that ranked second in frequency had to do with difficulty in obtaining the services of a doctor. This subject is going to be covered thoroughly by other members of the panel so, again, we will confine our remarks to a few simple statements. First, it is easy for the hospital, clinic or full time institutional specialist to formulate rules to solve this problem.

His contribution, however, will stop with his ideas and not involve his departure from warm blankets in the middle of the night to save organized medicine from criticism coming from an ever increasingly demanding public. Secondly, persons who refuse to retain a family doctor are the ones most likely to complain when a doctor is not at their beck and call. Third, no matter how difficult the problem or how unreasonable the demands of the public may be, we must try to find a solution. We must try to educate the public to have a regular family doctor, and we must have a rotating service available to those who refuse to do the same. Fourth, the one eventuality that we all most fear and dread, namely a depression, would cure this ill very quickly.

There is one additional point that we should mention at this time. The complaints we have received most frequently involved young doctors rather than middle aged or older ones. The eight hour day enjoyed by our interns and residents in private hospitals, which we all seem to tolerate, is a venomous situation and contributes greatly to this problem.

### **Standards Must Be High**

The remaining complaints had to do with the standard of professional care and the manner of execution.

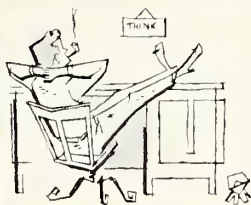
We are all aware of the necessity of rendering good professional care. Ability will always vary but in the absence of unusual ability all of us by conscientious endeavor can do a job well and, if we cannot, we know it and should get help. The liberal use of consultation hurts no one and immeasurably helps the patient.

Next, we should like to touch upon the general conduct of the doctor which, when in arrears, prompts patients to complain. If one is hurried, slovenly, careless, irritable, sarcastic or rude, it is noticed by the patient. We are consulted when someone is in trouble. These problems to our patients are more important than anything else in the world. If we give these problems very little time or if in the course of the interview we are interrupted several times, it is noticed. If the interruptions have to do with our farm, our investment problems, social organizations or medical politics, how would we feel if we were the patient? If we are

(Please turn to Page 640)



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(Continued from Page 638)

irritable because of fatigue or illness, we can take a vacation and, certainly, we can save our sarcasm for our wives and our rudeness for our in-laws or creditors. By the same token, we can see that our offices are neat and we can be personally clean and tidy. We can be dressed with good taste. We do not advocate that we be attired in stiff hat and cut-a-way coat, but we do feel that we can be clad in a clean gown or office jacket in our office and a coat and tie for hospital calls. Would it not bother anyone's photophobia to encounter a calling doctor in the hospital room with an open shirt with pictures on it suitable for display or even capable of producing gasps on the beach at Miami? We are of a noble profession. Would we not be surprised and disappointed to see our minister making calls with open shirt and no coat?

We, of recent months, have been the recipients of a great deal of criticism in the lay press and in lay conversations. It is our belief that not all of this is because of us, but neither is it in spite of us. To compare ourselves with the legal profession, the real estate or the securities business, is pure rot. We belong to a profession that does not deal with paltry dollars. We deal with human life. This is no time for slumber in the chamber of self-satisfaction nor is it the time to practice the easy art of defeatism. Let us assure you that this paper was not written in an atmosphere of defeatism, cynicism or criticism but rather in the clear air of optimism and hope. Maybe our problems are not easily solved, but nothing worthwhile is easy. All we need is the courage of our forefathers. Kipling summed this up beautifully in a poem as follows:

We are afflicted by what we can prove;  
We are distracted by what we know—  
So—Ah so  
Down from our heaven or up from our  
mould,  
Send us the hearts of our fathers of old!

Our forefathers had problems and they solved them pretty well, for we certainly inherited a wonderful profession. Dr. M. J. Marks recently called our attention to the ideal physician envisioned by Robert Louis Stevenson

in his dedication of the Underwoods. He wrote, "He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact tried in a thousand embarrassments; and what are most important, Herculean cheerfulness and courage. So that he brings air and cheer into the sick-room, and often enough, though not so often as he wishes, brings healing."

Yes, we do have a fine heritage, and not one that just happened, it was built stone by stone by courageous and devoted men.

### **"We Must Not Forget Our Duty"**

As to the present, we are aware of the countless hours being spent by fine high principled and unselfish men in the private practice of medicine. These wonderful doctors do so much to preserve our way of life and practice. Our collective scientific accomplishments are superb. It is fine for us to bring these truths to the attention of the public by every means at our command. It is also permissible for us to oppose trends which threaten private practice. But as we shout our virtues and clamor for our rights, we must not forget our duty. We must not fall into the rut of well-known pressure groups that loudly insist upon their rights but totally forget their obligations. We had better spend more time at our county medical society meetings in pursuit of scientific advancement and learning and less at political quibbling. When announcements come from an official source, they must be accurate and truthful. We must put our house in order for, if we do not, some one will do it for us. Our grievance, ethics and other committees can accomplish this if we stand together and give them our support. If we stand for what is right, no one can destroy us. If we face and accept our obligations, we can live up to our magnificent heritage. We can pass on to our sons the noblest of all professions.

## GREENWOOD DOCTOR, IN GERMANY, WRITES OF DUTY, TRAVEL OPPORTUNITY



The 320th General Hospital, United States Army, at Landstuhl, Germany, is pictured showing the modern one and two story buildings. Regular hospital facilities are augmented by a special services library, Red Cross headquarters, chapel, newsstand, flower shop, nursery to care for visitors' children, postal services, and officers' quarters.

**G**EORGE A. TILEY, Lieutenant Colonel in the Medical Corps of the United States Army, writes *THE JOURNAL* from Landstuhl, Germany, where he is assigned. Before entering service last year, Doctor Tiley had been a practicing physician and surgeon in Greenwood for 15 years. He was graduated from the University of Bern, Switzerland, in 1935, was licensed in Indiana in 1937, and after being on the staff at St. Francis Hospital, Beech Grove, he established his practice in Greenwood.

His letter written April 24, 1954 follows:

"I was more than pleased to receive the March issue of the Indiana State Medical Association *JOURNAL*. I have read this magazine with much interest. One of the headings I noticed was "We invite you to tell a story."

The only story I could tell would be about my experience in Germany in the Army.

I am located in the 320th General Hospital in Landstuhl Army Medical Center. It is a hospital of 1000 beds and is operated very efficiently by a group of well trained doctors from all over the United States. I am the commanding officer of the Out-Patient Service and Pharmacy; also the commanding officer of the 566th Medical Detachment (Surgical).

Most of the officers are allowed to bring their cars to Europe with them. In fact I have driven all over Germany. Here are some of the cities I have already visited in the 6 months I have been here—Cuxhaven, Hamburg, Bremerhaven, Bremen, Hannover, Kassel, Duesseldorf, Koeln, Bonn, Koblenz, Bad Kreuznach, Wiesbaden, Mainz, Worms, Frankfurt, Darmstadt, Mannheim, Heidelberg, Kaiserlautern, Karlsruhe, Stuttgart, Muenchen, Berchtesgaden, and Gar-



misch-Partenkirchen—only to mention a few. I have already seen the U. S. Zone of wartorn Europe.

We have just finished a Surgical Pathological Conference of two and a half days with Dr. Lauren Ackerman of St. Louis as the moderator. I must say that the Army has been good to me

and I am enjoying my tour of duty in the European theatre of occupation.

Enclosed is a picture of the hospital at which I am located and a description of its services.

Previous to going into the Army I had practiced medicine in Greenwood, Indiana, for 15 years."

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# -in 1908



Every now and then we come across an interesting bit in an old copy of *THE JOURNAL*. Sometimes there is humor created by the span of years; sometimes a similarity to today's problems; and sometimes just some oldfashioned horse-sense. These we culled from *THE JOURNAL* of April, 1908:

## THE AUTOMOBILE FOR THE DOCTOR

The Journal of the American Medical Association for March 7, 1908, very properly devotes a number of pages to the automobile as a conveyance for physicians. As might be expected, not all of the contributors to the pages devoted to opinions from physicians are of the same mind as to the value of the automobile for the doctor, but the general verdict is favorable. As a vehicle for use the year around the use of the automobile is confined principally to cities having well paved streets. For ordinary country roads the automobile is adapted to summer months only. But even for limited use the automobile, on account of the saving in time, is a practical conveyance for the doctor to own. Very de-

pendable cars are now made which cost less than \$1,000, and several well-known makes cost \$500 or less. The trouble and expense arising from the use of a car depends very largely upon the operator, though to some extent upon the conditions under which the car is operated. However, two men owning cars of the same make and pattern and operating them over the same roads and for the same length of time may have entirely different results as to trouble and expense, all depending on the manner in which the cars are used. An automobile is in many respects like a horse; it must have some kind of care and be driven judiciously. If so handled it will give the user general satisfaction by proving economical, time saving, and a source of pleasure. Any well known make of car will do this now.

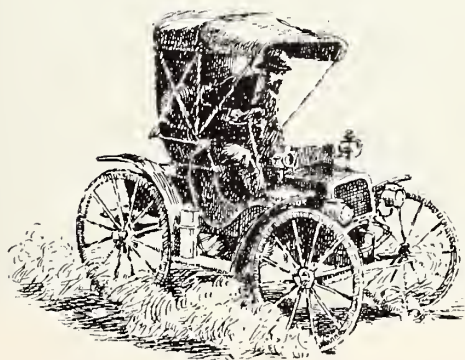
Then as now . . .

All things being equal, we trade with the dry goods merchant, the grocer and the butcher who is our regular patron. That is reciprocity.

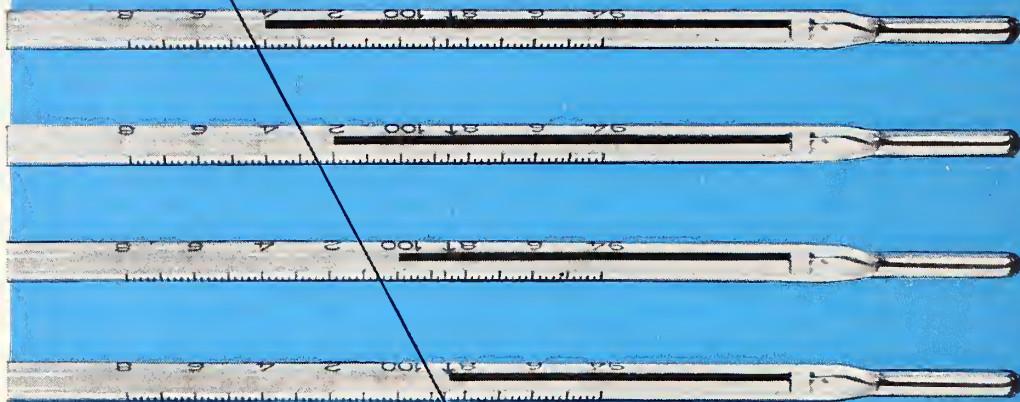
The members of the Indiana State Medical Association own *THE JOURNAL*. A certain number of reputable firms advertise in *THE JOURNAL* and thus are our patrons. All things being equal, we owe them our patronage in return. Reciprocity is the basis of all trade.

We are professional men in every sense of the word; we have the mental labor of lawyers, the moral standing of ministers, the technical knowledge of organized artisans, and the business qualifications of school children. The average man will give a lawyer \$300 to \$500, together with a lifetime's praise, to keep him out of the penitentiary for from two to ten years, and at the same time he will raise a phosphorescent glow and a kick that can be heard around the world if a doctor charges him \$50 to \$100 to keep him out of hell for a lifetime.

—*Texas State Journal*.







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English, A. R., et al.: Antibiotics Annual (1953-1954),  
New York, Medical Encyclopedia, Inc., 1953, p. 70.

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## Deaths . . .



**Jacob T. Oliphant, M.D.**, former president of the Indiana State Medical Association, died May 16 at his Farmersburg home after a long illness. He was 73 and had retired after devoting 45 years to the general practice of medicine. From 1945 to

1953 he was a member of the Indiana State Board of Health, serving the last four years as chairman.

A native of Monroe county, Dr. Oliphant was graduated from the Medical College of Indiana at Indianapolis in 1905 and established his practice in Farmersburg that year. He served as an Army Medical Corps lieutenant during World War I. Twenty years of service to the Indiana State Medical Association membership on various committees was recognized when he was elected president in 1944; he continued to serve on ISMA committees through 1952. Doctor Oliphant was a former member of the Editorial Board of *THE JOURNAL*. He was also a member of the Indiana State Board of Medical Registration and Examination from 1937-40. In recognition of his many outstanding contributions to the advancement of health in Indiana, the professional library at the State Board of Health Building, Indianapolis, was named the Jacob T. Oliphant Library.

**Lucian W. Smith, M.D.**, died April 4 at his home in Warren after a five weeks illness. A native of Ann Arbor, Michigan, he spent most of his life in Indiana. He was graduated from the Medical College of Indiana in 1905. He practiced briefly in Liberty Center and Converse, then established his practice in Warren 45 years ago. Doctor Smith served as a lieutenant during World War I. He was

a member of Huntington County Medical Society and the Indiana State Medical Association.

**Eugene L. Bulson, M.D.**, Fort Wayne ophthalmologist and otolaryngologist for 30 years, died suddenly in his home April 13 after a heart attack. He was the son of Albert E. Bulson, M.D., editor of *THE JOURNAL* from 1908 through 1932. He was a native of Fort Wayne. Doctor Bulson received his medical degree from Indiana University School of Medicine in 1920 and served his internship at Indianapolis City Hospital. He served in World War I.

Always active in medical organizations, Doctor Bulson held memberships in local, state, national and international groups. He was a Fellow of the American College of Surgeons and belonged to many specialty organizations. He had served continuously from 1932 through 1953 on committees and as a section officer of the Indiana State Medical Association. He was a member of the Editorial Board of *THE JOURNAL* and edited Fort Wayne Medical Society's "Cauduceus" for many years.

His hobby was magic. He had served as president of the Fort Wayne Magician's Club for 25 years and was a member of the Parent Assembly of the Society of American Magicians and of the International Brotherhood of Magicians.

**William D. Weis, M.D.**, 80, died April 18 in St. Margaret's Hospital, Hammond, where he had served his internship following his graduation from the Chicago College of Medicine and Surgery (now Loyola). He had been ill since 1951 when he was injured in an automobile accident.

Doctor Weis spent 46 years in private and public health service in Lake county. In 1908 he organized the Hammond city health department which he conducted for 10 years.

In 1934 county commissioners appointed him to develop and conduct a modern health department. He was still head of that department at the time of his death.

Doctor Weis was a former president of Lake County Medical Society of which he was an honorary life member. He was a senior member of Indiana State Medical Association.

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**Arthur J. Micheli, M.D.**, Indianapolis surgeon and specialist in gynecology, died April 22 in his home where he had been ill several months with a heart ailment. Born in Germany, Doctor Micheli was brought to the United States as an infant. He served in World War I. He was a 1916 graduate of Indiana University School of Medicine and later did postgraduate work in Vienna, Austria. Doctor Micheli was an active member of Indianapolis Medical Society and the Indiana State and American Medical Associations.

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**Jonathon E. Comer, M.D.**, Mooresville physician for many years, died April 25 in the home of his son, Dr. Kenneth Comer, after a week's serious illness. He was 78.

A native of Indianapolis, Doctor Comer was graduated from the Indiana Medical College in 1905, practiced in Bargersville and Waverly before establishing his practice in Mooresville. From 1918 to 1948 he also had offices in Muncie. He was the founder of the Comer Sanitarium in Mooresville now operated by his sons, Drs. Kenneth and Charles Comer. All were specialists in proctology. Doctor Comer was a member of Morgan County Medical Society, a senior member of Indiana State Medical Association, and member of American Medical Association.

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**Paul R. Irey, M.D.**, 58, died April 28 in his home in Plymouth a few minutes after returning from making a house call. He had been a physician in Plymouth since 1929. A native of Michigan, he was a veteran of World War I. He received his medical degree from Loyola University in 1929. Doctor Irey was a staff member of St. Joseph's and Northern Indiana Children's Hospitals, South

Bend. He was an active member of Marshall County Medical Society, the Indiana State and American Medical Associations. He also was a member of the Association of Pennsylvania Railroad Surgeons.

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**Claudius L. Boyd, M.D.**, Vincennes physician for many years, died in Good Samaritan Hospital May 1 following a cerebral hemorrhage. He had been in ill health three years and recently had discontinued making personal calls. He was 76.

Doctor Boyd had spent his entire medical career in Vincennes. He obtained his medical degree in 1903 from New York University College of Medicine. In addition to his private practice he served many years as physician for the Baltimore and Ohio railroad and several terms as Vincennes city health officer. He was a senior member of Knox County Medical Society which he had served as secretary; a senior and Fifty Year Club member of Indiana State Medical Association and a member of American Medical Association.

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**W. Marshall Varble, M.D.**, 76, Jeffersonville, died May 2 in his home after being ill for two years. He had been in practice for 50 years and had served as Clark county health commissioner for 40 years. He was graduated in 1901 from Kentucky University Medical Department, Louisville. He was a member of Clark County Medical Society and a senior member and Fifty Year Club member of the Indiana State Medical Association.

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**Ralph Wilson, M.D.**, practicing physician in Shirley for 57 years died May 6 in a New Castle nursing home. He had been ill for two years. Doctor Wilson was 84 years old. A native of Hancock county, he was graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1896. Doctor Wilson enjoyed the distinction of being a 50 year member of Henry County Medical Society, the Friends church and the Shirley Masonic lodge. He was also a senior member and Fifty Year Club member of Indiana State Medical Association.



**Tell I.U. Medical Students**

(Continued from Page 629)

tive secretary. The outline of the work of the county medical society and the state association introduced the medical students to the advantages of joining fellow physicians in an organized effort to improve community health.

Mrs. Harry C. Harvey, Fort Wayne, president of the Woman's Auxiliary to the state association, drew on personal experience to speak of "The Role of a Physician's Wife in the Practice of Medicine"; Pierre de Tarnowsky, sales training director for Mead Johnson and Company, Evansville, explained the services representatives of pharmaceutical firms offer doctors. He called his remarks "Postgraduate Education on Legs."

The Blue Shield Plan or "How to Get Paid and Like It" was the topic discussed by Dr. Walter L. Portteus, Franklin, president elect of ISMA. Long active in the "Doctors' Plan" to ease the burden of illness, he reported record benefits paid to a record number of policyholders.

There was a question and answer period; a social hour in the Ballroom foyer with Mead Johnson representatives acting as hosts; and dinner, courtesy of The Blue Shield Plan.

Mrs. Charles Sewell, Otterbein, speaking at the dinner, recalled many stepping-stones from the days when rural living was cruelly difficult and not too healthful to the present streamlined living on farms and in small towns. Through her association with the American Farm Bureau and more recently with the American Medical Association she has helped achieve higher levels of community health in rural areas. She paid tribute to the women of America's farms and to the wives of America's rural doctors in developing her subject "They Also Serve".

Other members of the Committee on Rural Health who helped plan the get-together with the senior medical students, and all of whom attended the program, were Drs. John M. Bretz, Huntingburg; Louis E. How, Lakeville; W. G. Pippenger, Brook; Ralph C. Eades, Valparaiso; and Eli Goodman, Charlestown.

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# NEWS NOTES—from State and Nation

## Health Education Workshop at I.U. on August 13-27

A school and community workshop in health education for representatives of voluntary health agencies, professional organizations and government agencies has been planned for the Indiana University campus at Bloomington from August 13 through August 27.

School superintendents, public health officials, and directors of voluntary agencies are asked to assist in the selection of participants who will profit from the experience and, in turn, help their communities develop better health programs.

Sponsors of the Workshop, which will be held in West Hall, are Indiana University; the Indiana State Board of Health and the State Department of Public Instruction of Indiana. The Indiana State Medical Association, and many voluntary agencies are co-operating.

Directors are J. Keogh Rash of the School of Health, Physical Education and Recreation at I.U. and Hester Beth Bland, Division of Health and Physical Education, Indiana State Board of Health. Full details may be obtained from either director.

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**Dr. James H. Stygall**, Indianapolis, will serve as chairman of the Section on Cardiovascular Diseases at the 20th annual meeting of the American College of Chest Physicians in San Francisco, June 17-20.

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**Lt. Comdr. Ralph W. Dreyer**, former physician at Knightstown, sailed from Norfolk, Virginia, May 3 on the U.S.S. Randall of the U. S. Navy amphibious forces for a five month tour in the Mediterranean area. Ports of call will include Gibraltar, Barcelona, Cannes, Genoa, Naples, Algiers, Athens and Turkey. Part of the time they will operate with the Sixth Fleet and the British Navy.

Dr. Dreyer expects to be back in the U. S.

in October and will be released from duty on January 7, 1955. Mrs. Dreyer and their son, David, will sail for southern Europe June 15 and will meet Dr. Dreyer in France.

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"Revista de Neurologia Clinica", published in Madrid, Spain, carried an abstract of an article written by **Drs. A. Kunkler and Harris B. Shumacker** of the Indiana University Medical Center in a December issue just received by THE JOURNAL. The paper was originally published in "Surgery."

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**Three fellowships in coloproctology** worth \$1,000, \$900 and \$800 each will be awarded to three outstanding medical institutions annually by the International Academy of Proctology. Members of the Academy meeting recently in Chicago made the first award to the Jersey City Medical Center. The second and third awards for 1954 are expected to go to midwest and California institutions. Delegates also voted to present gold, silver and bronze awards and certificates to the three most outstanding world proctologists each year beginning with the 1955 meeting. Those awards will be made in New York next April at the seventh annual meeting.

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**Dr. C. A. Burroughs**, who has been in practice in Frankfort since 1932, has retired to become full time medical director for the Peoples Life Insurance Company effective July 1. **Dr. Fred Flora**, Clinton County native and I. U. graduate, will establish private practice in the offices now occupied by Dr. Burroughs in Frankfort. Dr. Flora will go to Frankfort July 1 after completing his internship in an Akron, Ohio hospital.

---

**Dr. G. A. Dickinson**, Petersburg, has opened a part-time office in Washington at 111 East Main Street. He will specialize in diagnosis and treatment of medical diseases.



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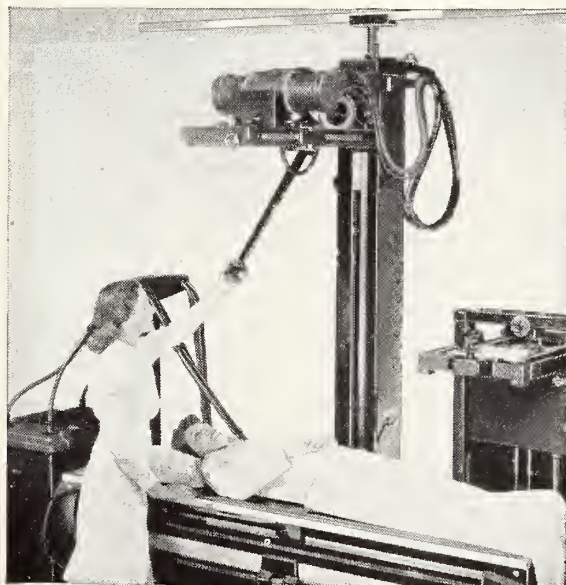
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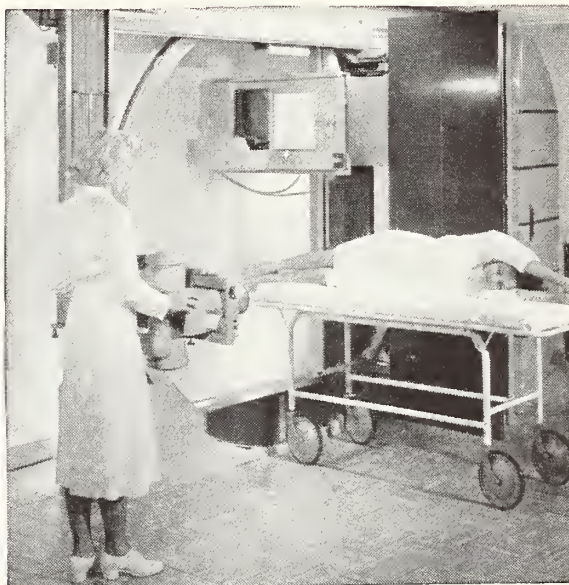
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A native of Washington, Dr. Dickinson practiced in Petersburg before entering the army in 1941. He was in service for five years. He owned and operated a hospital in Kentucky for three years, did postgraduate work at Emory University, Atlanta, served a year at a VA hospital in Jackson, Mississippi and returned to Petersburg two years ago. He will maintain offices in both Petersburg and Washington.

Dr. A. B. Scales, who has been commanding officer of the hospital at Fort Benjamin Harrison, Indianapolis, and post surgeon there, has been discharged and will be associated with Dr. H. K. Stork at Huntingburg at Stork Memorial Hospital. Dr. Scales is a graduate of I. U. School of Medicine and a veteran of four years service in the southwest Pacific. Before entering service he practiced medicine and surgery in Oakland City and Evansville and for a short time with Dr. Stork in Huntingburg.

Dr. Hawthorne C. Wallace, Crawfordsville, spent the month of May in Europe. He attended the convention of the Association of Surgeons of Great Britain and Ireland at Leeds early in May and later attended some surgical clinics in London and Paris. Mrs. Wallace accompanied him.

#### OB-GYN Congress Set for December in Chicago

The sixth American Congress on Obstetrics and Gynecology will be held in the Palmer House, Chicago, December 13 through December 17. Sponsors are the American Committee on Maternal Welfare, Inc. and the American Academy of Obstetrics and Gynecology. It will bring together representatives of medicine, nursing, public health and hospital administration.

Information about the meeting may be obtained from Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Avenue, Chicago 3, Illinois.

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### Indiana Members Attend Goiter Association Meeting

Four Indiana doctors, members of the American Goiter Association, attended the annual session of that group in the Somerset Hotel, Boston, April 29, 30 and May 1.

Those registering for the Boston session were Drs. Glenn W. Irwin, D. C. Hines, L. H. Kornafel, and Frank B. Ramsey, all of Indianapolis.

The National Gastroenterological Association will hold its Sixth Annual Course in Postgraduate Gastroenterology at the Shoreham Hotel, Washington, D.C., on October 28, 29, and 30. Drs. Owen Wangenstein, professor of surgery at the University of Minnesota Medical School, and Dr. I. Snapper, director of medical education at Beth-el Hospital, Brooklyn, New York, will again serve as co-chairmen and will be assisted by a distinguished faculty.

Full information and enrollment blanks may be secured by writing National Gastroenterological Association, Department GSJ, 33 West 60th Street, New York 23, New York.

Dr. Russell M. Blemker left Greensburg recently for Eugene, Oregon, where he has assumed a position on the staff of the health service of the University of Oregon. Doctor Blemker had been in practice in Greensburg since 1937 with the exception of the time he

spent during World War II as the first medical volunteer from his community. He said he was making the change to benefit his health.

Dr. Louis Walker, I. U. graduate, who served his internship and residency at Indianapolis General Hospital, has established his practice in the offices formerly occupied by Dr. Blemker and will also occupy the Blemker residence at 332 East North Street, Greensburg.

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### I.U.'s Dr. Hine on National Program

Maynard K. Hine, D.D.S., dean of the School of Dentistry, Indiana University Medical Center, is one of the six lecturers for the annual meeting of the American Institute of Dental Medicine which will be held at the Desert Inn, Palm Springs, California, October 31 through November 4.

Doctor Hines' subjects will include "Principles of the Treatment of Peridental Disease", "Oral Microbiology", and "Diseases of the Tongue and Other Lesions."

Other lecturers will be William A. Albrecht, Ph.D., University of Missouri; Charles H. Best, M.D., D.Sc., University of Toronto; Gordon M. Fitzgerald, D.D.S., University of California; Ernest Jawetz, Ph.D., M.D., University of California; and Joseph P. Weinmann, M.D., University of Illinois.

All seminar lecturers will participate in a roundtable forum concerning the application of their subjects to the practice of dental medicine.

Applications and full information may be secured from the executive secretary, Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, California.

**Dr. Don C. Manuel**, who has practiced in Edinburg since 1950, has gone to California where he plans to remain and to establish an office after an extensive vacation. Dr. W. W. Stogsdill who has been associated with Dr. Manuel for a short time, will continue to practice in the Manuel office and will also retain his practice in Franklin.

**Dr. R. Perry Reynolds**, Garrett physician and DeKalb county coroner, was recently elected president of the newly formed Indiana Coroners Association.

**Dr. Lowell J. Durham**, who had been practicing at Mount Morris, Michigan has opened an office for the general practice of medicine at 1012 Harrison street, LaPorte. He is a graduate of the College of Medical Evangelists, Loma Linda, California and served his internship at St. Joseph's Hospital, South Bend. He is a member of the American Academy of General Practice. Dr. Durham is the son of O. C. Durham, chief botanist at Abbott Laboratories, North Chicago.

**Dr. Roger E. Lingeman**, a 1943 graduate of the Indiana University School of Medicine and World War II veteran, has opened an office for the practice of medicine at 2081 North Emerson, Indianapolis. Before moving to Indianapolis he practiced in Eaton.

Upon completion of his internship at Indianapolis General Hospital on July 1, **Dr. Kenneth J. Rudolph** will return to his home town, Boonville, where he will enter the practice of medicine with Dr. Robert P. Dimmett. He is a graduate of I. U.<sup>o</sup> School of Medicine and served in the U. S. Navy.

**Dr. Wayne Schrepferman**, who will complete his internship at St. Vincent's Hospital, Indianapolis, in June will be associated in the practice of medicine with Dr. James A. Alford in Hamilton after July 1.



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### Pharmaceutical Association To Meet at French Lick

1954 convention of the Indiana Pharmaceutical Association will be held June 15, 16 and 17 at the French Lick Springs Hotel.

Among prominent speakers who will be heard are Dr. Ivor Griffith, Dr. Bert R. Mull, Dr. Robert Swain, Dr. Paul Olsen, "Tommy" Adkins, John McCartney and former Senator John McGuire. A large number of retail pharmacists will participate in the program and the Travelers' Auxiliary has planned outstanding entertainment for the three day meeting.

**Dr. Robert Hayter**, who has just completed a four year residency in surgery at Indianapolis General Hospital, has established practice in Lyons in offices formerly occupied by Dr. Michael Manzie. Doctor Hayter is a graduate of the University of Oregon, did postgraduate work in surgery at Polyclinic Hospital, New York, and is a veteran of World War II. Mrs. Hayter, a native of Linton, was in nurses training at Indianapolis General Hospital.

**Dr. J. L. Ferry**, Whiting, was the speaker at a recent meeting of the Gary Community Welfare Council when he discussed problems of adoption. Doctor Ferry has two adopted children and spoke from a personal as well as professional viewpoint. He outlined measures necessary to protect both children and adoptive parents.

**Dr. L. Paul Hart**, Evansville, has been certified by the American Board of Surgery as a diplomate in general surgery. Dr. Hart was in general practice in Evansville until 1949 when he resumed his studies at Washington University, St. Louis. He has been specializing in general surgery in Evansville since 1952.

**Dr. J. M. McFadden**, Lafayette, is supervising the pathological laboratory at Dukes Hospital, Peru. Doctor McFadden is the pathologist at St. Elizabeth's Hospital, Lafayette, but will devote two days a week to the new post in Peru.



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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

April 4, 1954

Roll call showed the following present: James W. Denny, M.D., chairman; Walter L. Portteus, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; Robert Hollowell, attorney; J. A. Waggener, executive secretary; Robert J. Amick and Kenneth W. Bush, field secretaries.

### Membership Report

Number of members April 2, 1954	-----3,574*
Number of members April 2, 1953	-----3,400
Gain over last year	-----174
Number of members December 31, 1953	...3,820

\* Includes

122 in military service (gratis)
79—\$10.00 members (residents and interns)
257—senior members
56—members, dues remitted by Council
2 honorary members

AMA dues paid: 1952---3,569; 1953---3,625\*\*;  
1954---3,159\*\*.

\*\* Includes 420 members permanently exempted in 1952.

### Headquarters Office

Mr. Amick and Mr. Bush reported on their activities in the field during the past month.

Statements of Receipts and Expenditures for February and March for the Association and *THE JOURNAL* were accepted by consent.

### Annual Convention, Murat Temple, Indianapolis, October 24, 25, 26, 27, 1954

The secretary reported that the Studebaker Corporation of South Bend had agreed to furnish the Association with a new Studebaker, to be given away at the October convention. The arrangements were completed through the efforts of Dr. F. R. N. Carter, and the secretary stated that he had agreed to give the company a page ad in *THE JOURNAL* for twelve issues, in addition to displaying the car at the convention.

Inasmuch as the Association had contemplated giving vacation trips to Nassau as attendance prizes and since the automobile will be available for the grand prize, the secretary recommended that a trip to Nassau be given to someone in the exhibits, to be awarded through a drawing to exhib-

itors and representatives only. This was approved by consent.

Dr. Portteus asked the committee to consider the advisability of extending the annual meeting one day and inviting the ancillary groups to hold their annual meetings in conjunction with the Association, pointing out that this would serve to cut down the number of meetings during the year and should improve the attendance at both the Association convention and the meetings of the respective groups. It is his suggestion that by adding an extra day to the meeting these groups could be given a full day or a day and a half to arrange their programs to suit their own needs.

### Organization Matters

*Midland Finance Company.* The secretary presented the request of the Midland Finance Company for approval of their collection plan, and upon motion of Drs. Myers and Clarke it was voted that no agency such as this be recommended to the membership of the association.

*Public relations program.* Dr. Earl W. Mericle, chairman of the Committee on Public Relations, appeared before the committee and presented an outline for the proposed public relations program, stating that the committee had employed Keeling and Company, Indiana's largest advertising and public relations firm, to work out the details of the campaign. It is proposed to use four one-minute spot announcements per week for a period of 13 weeks on 37 radio stations. It was also proposed to use two five-minute television shows per week for 13 weeks on 7 Indiana television stations. It will be necessary to tailor the above program to fit the budget.

Upon motion of Drs. Clarke and Portteus the committee approved the proposal of the Public Relations Committee and instructed them to proceed with definite plans for the program.

*Party for senior medical students.* Dr. Joseph Dudding, chairman of the Committee on Rural Health, appeared before the committee and outlined the program which his committee had set up for the senior medical students and their wives, to be held in the Columbia Club, Indianapolis, on Saturday, May 1. The program was approved on motion of Drs. Portteus and Myers.

*Principles of Medical Ethics.* The secretary read a letter from the A.M.A. under date of March 30 requesting an answer to certain questions concerning the Principles of Medical Ethics. Upon motion of Drs. Portteus and Clarke the secretary was instructed to mail copies of this material with a ballot to each county medical society, asking that they express their opinion and that the question-

naires be returned in time that this matter might be discussed by the Council. The field secretaries also were instructed to call this matter to the attention of the county societies as they made their visits.

*Indiana Interprofessional Committee on Eye Care.* A letter received from Dr. Carl J. Rudolph, together with a copy of the minutes of the meeting of the Indiana Interprofessional Committee on Eye Care, was read, in which it was requested that participating groups in the organization contribute the sum of \$50.00 to carry on the work of the committee. The request was approved on motion of Drs. Portteus and Clarke.

The secretary read, for the information of the committee, the resolution on veterans care adopted by the House Committee on Veterans Affairs of the United States Congress.

Dr. Portteus reported on the meeting held March 20 with the presidents and secretaries of other state medical associations, stating that he thought much was gained by those present from the interchange of ideas and everyone seemed to think the meeting served a good purpose.

#### The Journal

*Report on advertising* for the first quarter of 1954 was accepted by consent:

Total, first quarter of 1953	\$5,897.91
Total, first quarter of 1954	8,634.23
Gain over first quarter last year	2,736.32

#### New Business

A letter from the office of the Governor, requesting the Association to appoint a representative on the Advisory Health Council, was read, and upon motion of Drs. Portteus and Clarke, Dr. J. William Wright, Sr., is to be asked to accept this appointment.

Dr. Portteus stated that at the recent meeting of the Board of Directors of Blue Shield the Blue Shield Plan had agreed to make available to any physician copies of the pamphlet used by Dr. Portteus for distribution to patients, explaining various charges for medical and surgical services. The offer of Blue Shield was accepted by consent and the secretary was instructed to call attention to this offer in the next issue of the News Letter and to distribute a copy of the pamphlet.

The committee suggested that the secretary work with the attorneys of the association and prepare a simple assignment form which could be incorporated in the News Letter for the information of physicians.

There being no further business the committee adjourned to meet again at 6:30 p. m. Saturday, April 24, 1954, in the conference room at the Union Building, Indiana University School of Medicine campus, Indianapolis.

## EXECUTIVE COMMITTEE

April 24, 1954

Roll call showed the following present: James W. Denny, M.D., chairman; Walter L. Portteus, M.D.; E. H. Clauser, M.D.; Wm. Harry Howard, M.D.; Roy V. Myers, M.D.

Albert Stump, attorney; Robert Hollowell, attorney; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

#### Membership Report

Number of members April 23, 1954	3,637*
Number of members April 23, 1953	3,518
Gain over last year	119
Number of members December 31, 1953	3,820

\* Includes

123 in military service (gratis)
81—\$10.00 members (residents and interns)
263 senior members
56 members, dues remitted by Council
2—honorary members

AMA dues paid: 1952—3,569; 1953—3,626\*\*; 1954—3,421\*\*.

\*\* Includes 420 members permanently exempted in 1952.

#### Headquarters Office

Mr. Amick reported on his activities during the past three weeks, stating that he had discussed the matter of the Welfare Department approving an outstate physician for care of Indiana welfare recipients with the societies in his district involved in this matter. After discussion, upon motion of Drs. Portteus and Clauser, the executive secretary was instructed to send a letter to the State Welfare Department reiterating the position of the state medical association that Indiana physicians should be utilized to take care of welfare work as long as they are available and willing to do so. It was also suggested that this matter be referred to the Liaison Committee with the State Welfare Department.

Discussion was also held relative to the political situation, in which Dr. Portteus queried the field secretaries as to whether or not they had compiled the card index on candidates for the state legislature with pertinent information, as proposed by the committee at a previous meeting. After discussion, it was agreed that the field secretaries should prepare such a card file immediately following the primary elections, copy of which is to be made up for the headquarters office.

Upon motion of Drs. Portteus and Clauser, the executive secretary is to prepare a letter to be



addressed to all candidates for the state legislature congratulating them on their public spiritedness in running for public office.

Mr. Bush reported on his activities during the past three weeks and gave report on the circulating tape library of the Association, reporting that 190 requests had been serviced since the first of January and that there were currently some 30 requests unfilled.

By consent it was agreed that the headquarters office will be closed all day on Saturdays during the months of May, June, July and August.

### Legislative Matters

#### National

A letter from the California Committee to Prevent Abuse of the Doctor's Draft Law was read, as well as a letter from Dr. Leonard H. Lieberman, and upon motion of Drs. Myers and Clauser the matter was tabled.

#### Annual Convention, Indianapolis, October 24, 25, 26 and 27, 1954

Dr. Portteus brought up the matter of considering the lengthening of the annual convention of the Association an extra day and for an effort to be made to bring in the ancillary groups of the

medical profession for their meetings to be held concurrently with those of the medical association. Following discussion of this matter and upon motion of Drs. Clauser and Howard, Dr. Portteus was asked to present his thinking to the Council and to recommend that a committee be appointed to act on his proposal.

### Organization Matters

Letter of appreciation from the Indiana Academy of General Practice was read in which they expressed the appreciation of the Academy for the cooperation of the headquarters office and the staff of the Indiana State Medical Association during the recent state meeting of the Academy.

Letter from The Indiana State League of Nursing Education was read in which they solicited the cooperation of the Indiana State Medical Association in stimulating interest in routine chest x-rays for all patients admitted to general hospitals and for pre-employment and periodic chest x-rays for all hospital employees in Indiana. By consent the secretary was instructed to write The League of Nursing Education telling them that the Association had always deemed this advisable.

Letter from the Indiana Public Health Association, inviting the state medical association to exhibit during the annual meeting of the public health

- Tailored to your needs by a qualified, long-established organization
- Your opportunity to gain peace of mind from office and business worries
- Our services cover:

Tax Returns  
Bookkeeping and Monthly Reports  
Servicing Delinquent Accounts—**No Commission**  
Instructing Office Personnel  
Fee Analysis and Comparative Statistics  
Public Relations  
Setting Up New Practices and Partnerships  
Reviewing Plans for Retirement, Investments and Insurance

No charge for initial survey and no obligation to engage our services thereafter. Survey and subsequent contacts made only at your request. Service on month-to-month basis at reasonable cost.

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association, to be held in Indianapolis on May 6 and 7, was read and the invitation was accepted by consent.

The committee had called to their attention the effort made by the Indianapolis Medical Society in stimulating interest in the Health Fair and the secretary was instructed to write a letter to the Indianapolis Medical Society complimenting them on their efforts and successful holding of the fair.

By consent the secretary was instructed to investigate the cost and procedure for obtaining exhibit space at the Indianapolis Union Railroad Station.

*Staggered committees.* Dr. Portteus presented a proposed amendment to the Bylaws of the Association in accordance with his previous discussion with the committee in which he recommended that standing and special committees of the Association be appointed on a staggered term basis so as to provide more continuity to the Association committee work. The proposed amendment, prepared by Mr. Hollowell, was approved on motion of Drs. Howard and Myers and referred to the Committee on Constitution and Bylaws.

A letter from the Cardiac-in-Industry Committee of the Indiana Heart Foundation was read in which approval was sought for the establishment of a Work Classification Unit at the Indianapolis General Hospital. Upon motion of Drs. Howard and Clauser the request is to be referred to the special Committee on Heart Disease of the Association with the request that they report their recommendations back to the Executive Committee.

*Malpractice insurance coverage.* The executive secretary asked for the establishment of a policy regarding the Association's participation with the

St. Paul Mercury Indemnity Company in the field of malpractice insurance coverage for the members of the Association, stating that he understood the Association had formally approved the St. Paul Mercury Indemnity Company as the official carrier of malpractice insurance for the membership and had approved the contract currently being offered physicians in this state. The policy which he desired to be clarified was as to whether or not the Association should actively promote this insurance carrier to the membership of the Association.

The matter was thoroughly discussed, some members of the committee calling to mind that it was their impression that the Association had agreed to promote the St. Paul policy but that it had failed to do so. Upon motion of Drs. Portteus and Howard, the president was requested to appoint a special committee to study this entire matter. The president appointed the following committee to undertake this study: James M. Leffel, M.D., Indianapolis, chairman; Cleon A. Nafe, M.D., Indianapolis; Raymond R. Calvert, M.D., Lafayette; Lawson J. Clarke, M.D., Indianapolis, and Raymond C. Beeler, M.D., Indianapolis.

*Tippecanoe County resolution.* A resolution presented by the Tippecanoe County Medical Society relative to the activities of the State Board of Health in that county was referred to the Council for discussion.

The A.M.A. request for a statement of policy from the Indiana State Medical Association on their questionnaire concerning the Principles of Medical Ethics was referred to the Council for determination, by consent.

#### The Journal

*Report on advertising* was accepted by consent:

Projected income May, 1954	-----\$3,040.39
Advertising income May, 1953	---\$2,072.65

#### New Business

The secretary presented the request of the Indianapolis Press Club for a contribution of \$50.00 for their Gridiron dinner, and upon motion of Drs. Howard and Portteus the request was granted.

The secretary was authorized to attend the one hundredth anniversary meeting of the Indiana State Teachers Association, to be held at the Murat Temple, Indianapolis, Saturday, May 15, if his time could be so arranged.

There being no further business the committee adjourned to meet again at 11:00 a.m., Sunday, May 23, 1954, in the conference room at the Union Building, Indiana University School of Medicine campus, Indianapolis.

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## INDIANA STATE MEDICAL ASSOCIATION THE COUNCIL

April 25, 1954

The Council of the Indiana State Medical Association convened for its spring meeting at 10:20 a.m., Sunday, April 25, 1954, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Wm. Harry Howard, president, calling the meeting to order. Following roll call and reports of officers, Dr. Elton R. Clarke, chairman, presided.

Roll call showed the following present:

### Councilors:

First District -----Minor Miller, Evansville  
Second District-----Sam I. Rotman, Jasonville, alternate  
Third District-----William H. Garner, New Albany  
Fourth District -----J. E. Dudding, Hope  
Fifth District -----M. C. Topping, Terre Haute  
V. Earle Wiseman, Greencastle, alternate  
Sixth District -----W. U. Kennedy, New Castle  
Harry P. Ross, Richmond, alternate  
Seventh District ----Lester D. Bibler, Indianapolis  
Eighth District-----T. R. Hayes, Muncie  
Gordon B. Wilder, Anderson, alternate  
Ninth District-----Wemple Dodds, Crawfordsville  
H. E. Klepinger, Lafayette, alternate  
Tenth District -----J. Robert Doty, Gary  
James P. Vye, Gary, alternate  
Eleventh District ---Elton R. Clarke, Kokomo  
Twelfth District ----Maurice Glock, Fort Wayne  
Thirteenth District---Kenneth L. Olson, South Bend  
G. O. Larson, LaPorte, alternate

### Officers:

Wm. Harry Howard, Hammond, president  
Walter L. Portteus, Franklin, president-elect  
Roy V. Myers, Indianapolis, treasurer  
Frank B. Ramsey, Indianapolis, editor of *THE JOURNAL*  
David A. Bickel, South Bend, Associate Editor of *THE JOURNAL*  
James A. Waggoner, executive secretary

### Executive Committee:

James W. Denny, Indianapolis, chairman  
E. H. Clauser, Muncie, member

### Guests:

Cleon A. Nale, Indianapolis, A.M.A. delegate  
Alfred Elison, South Bend, A.M.A. delegate  
Wendell C. Stover, Boonville, A.M.A. delegate  
Earl W. Mericle, Indianapolis, A.M.A. alternate delegate, and chairman, Public Relations Committee  
William C. Wright, Fort Wayne, A.M.A. alternate delegate  
Hugh A. Kuhn, Hammond, and J. William Wright, Sr., Indianapolis, co-chairmen, Committee on Public Policy and Legislation

Leroy E. Burney, Indianapolis, secretary and State Health Commissioner, Indiana State Board of Health  
K. O. Neumann, Lafayette, president, Tippecanoe County Medical Society  
Gordon A. Thomas, Lafayette  
David L. Adler, Columbus  
John D. Van Nuys, Indianapolis, dean, Indiana University School of Medicine  
William D. Province, Franklin  
Albert Stump, attorney  
Robert Hollowell, attorney  
Robert J. Amick, field secretary  
Kenneth W. Bush, field secretary

Minutes of the January 24, 1954, meeting were approved as printed in the March 1954 issue of *THE JOURNAL*, on motion of Dr. Bibler, with one correction. Under "Preceptorship program," page 306, March *JOURNAL*, the minutes should read, "The Preceptorship Committee of the Indiana State Medical Association plans to entertain the members of the Executive Council of the Indiana University School of Medicine at the Athenaeum, April 12, 1954, with Dr. Grey Dimond of the University of Kansas as the principal speaker, etc."

### Reports of Councilors

The councilors announced the dates and places of their spring district meetings and extended invitations to officers and councilors to attend these meetings.

### Reports of Officers

The president and treasurer had no reports at this time.

*Dr. Walter L. Portteus*, president-elect: "I would like to talk a bit about a subject I mentioned at a previous Council meeting when I said that my slogan for my term of office would be 'unity'. . . . This may not be the proper time to discuss this particular thing, but I would like to ask the councilors to consider the possibility of extending the state meeting for an extra day for these reasons:

"1. I feel that the association is being split up into too many varied groups and into areas which tend to diminish the unity of the state medical association. I feel if we extend the meeting an extra day we might bring into the meeting the various groups to participate in one big meeting. This would provide a certain integration between the various specialty groups.

"2. This would increase the time for the exhibitors which would appeal to them. Anything we can do to make a better showing for them will certainly be of interest to the association.

"3. It would provide a place to meet more of your friends, and also it would have a tendency to reduce the number of meetings that you have to attend during the course of the year.

"4. It would increase the total attendance of the state meeting, and by having a larger attendance

I think we might be able to provide more topnotch speakers because we could pool our interests and money and get better speakers.

"The time has come to realize that after all we are all doctors. . . . With our diversity of interests it seems to me that it is very easy for the political forces to whip us one at a time. I think, in order to give the M.D.'s a just place in the picture, we have to get together. This idea of a combined meeting was tried out in Ohio and they had such a program in operation. I believe we must come closer together; I think we have to dovetail our thinking in order to put up a united front. I would like to recommend to the Council, if they so desire, or to you as chairman, Doctor, the appointment of a committee to try to bring about a little closer unity and to still keep the Indiana State Medical Association the top baby. If we are not careful, we are going to be councilors and officers of a rather hollow, sort of moth-eaten organization."

On motion of Drs. Bibler and Olson, the chairman of the Council is to appoint a committee to consider this matter and to report to the July meeting of the Council.

Dr. Howard suggested that in appointing such a committee, representatives of all of these allied organizations be invited to participate in order that any program formulated will be the combined thinking of all of these groups and not just a few men's ideas.

*Dr. Frank B. Ramsey*, editor of *THE JOURNAL*, asked for suggestions as to type of articles the councilors would like to have carried in the year-book number of *THE JOURNAL*, which will be the July issue.

Dr. Portteus asked if it would be possible to have a brief condensation of articles carried in other state journals in the *Indiana JOURNAL*, "the idea being that a lot of journals are received at the headquarters office, there are a number of interesting articles printed in other journals, and in this way it would be possible to parcel out a great deal of information to the members. It might be a way of disseminating work to other doctors."

#### Report of A.M.A. Delegates

(1) *Clarification of Section 5, Chapter I, of the Principles of Medical Ethics, relating to billing procedures.* The chairman stated that the Judicial Council of the American Medical Association, in order to report to the House of Delegates at the June meeting in San Francisco, desired to know the official position of the Indiana State Medical Association regarding the matter of billing procedures where two or more physicians render medical service to a single patient. He called upon Dr. Nafe, A.M.A. delegate, to discuss this matter.

Dr. Nafe reported that as a result of resolutions introduced by the Illinois and North Carolina State

Medical Associations, the Reference Committee on Amendments to the Constitution and Bylaws of the A.M.A. had expressed the feeling that until the Judicial Council made some other interpretation it was the consensus that joint statements should be considered unethical. Dr. Nafe also discussed the methods to be followed by health insurance companies in paying physicians when two or more serve a patient.

The secretary reported that answers received from 12 county medical societies to the questionnaire sent out by the state headquarters office showed that 7 societies favor combined billing, 4 render separate statements, and 1 society uses both methods of billing.

Following discussion by Drs. Bibler, Howard, Garner, Olson, Ellison, Clarke, Dudding, Portteus, Doty, Glock, Topping and Adler, the Council acted as follows on the questionnaire presented by the A.M.A.:

"1. Section 6 of Chapter I and Section 5 of Chapter VII of the December 1953 Principles establish the Principles of Medical Ethics with respect to 'receipt of remuneration for professional services' and 'Commissions'. The interpretation of these Principles by the Judicial Council is that it is unethical for two physicians who participate in the care of a patient to render a single bill."

On motion of Drs. Garner and Miller, the Council voted to support the present position of the Judicial Council of the A.M.A. as to the method of billing patients.

"2. Do the Principles of Medical Ethics of your state association differ in any significant respect to their application from Section 6 of Chapter I and Section 5 of Chapter VII of the Principles of Medical Ethics of the American Medical Association?"

The Council's answer is, "No. The Indiana State Medical Association is governed by and operates under the Principles of Medical Ethics of the A.M.A."

"3. What is the policy in your state concerning billing procedures when two or more physicians participate in the care of a patient?"

The Council approves separate billing, as stated in paragraph 1 above.

"4. How are payments made to physicians by health insurance agencies when two or more physicians serve a patient?"

In Indiana, the Blue Shield policy is optional for separate checks.

(2) *Shoulders Resolution.* Dr. Stover, A.M.A. delegate, discussed the Shoulders "Tennessee Plan" to insure military personnel and their dependents



through Blue Cross and Blue Shield plans, saying that in his opinion this proposal will be overwhelmingly defeated in the A.M.A. House of Delegates.

On motion of Drs. Bibler and Kennedy, the Council voted "that the delegates act on this Shoulders resolution according to their discretion."

### Unfinished Business

1. *Committee on Medical Court Testimony.* On motion of Drs. Olson and Dudding, the Council authorized the president to appoint the members previously nominated by the Council to membership on the Committee on Medical Court Testimony, in order that the committee may get to work. The members of this committee for 1954 therefore will be:

First District ----- Eugene W. Austin, Evansville  
 Second District ----- Virgil C. McMahan, Vincennes  
 Fourth District ----- George A. May, Madison  
 Fifth District ----- O. O. Alexander, Terre Haute  
 Sixth District ----- Frank Green, Rushville  
 Seventh District ----- Ben B. Moore, Indianapolis  
 Eighth District ----- Richard R. Owens, Muncie  
 Ninth District ----- H. C. Wallace, Crawfordsville\*  
 Tenth District ----- James F. Larrabee, Hammond  
 Eleventh District --- Russell W. Lavengood, Marion  
 Twelfth District ----- Lynn Elston, Fort Wayne  
 Thirteenth District --- Richard Horswell, Bristol

\* Nominated at April 25, 1954, meeting of Council. Nomination not yet made by Third District councilor.

2. *Medical Education Foundation Fund.* Dr. Denny, chairman, Committee on Medical Education and Hospitals, reported that the total contribution for the first three months of 1954 amounted to \$14,481.50 and that \$120,069.70 had been contributed by Indiana physicians since the beginning of the campaign in 1951.

Dr. Denny also reported that 150 hours of tape recordings are now available from the library in the headquarters office and that 190 hours have been requested and sent out from January 1 to April 1 to various county medical societies and individual physicians in the state.

3. *Election of A.M.A. alternate delegate.* On motion of Drs. Hayes and Glöck, Dr. Gordon B. Wilder of Anderson was elected to fill the unexpired term, ending December 31, 1955, of Dr. Lall G. Montgomery, Muncie, who is a delegate to the A.M.A. by virtue of being an A.M.A. section officer.

4. *Staggered committees.* On motion of Drs. Portteus and Kennedy, the following amendment to the By-Laws, presented by Dr. Portteus, was referred to the Committee on Constitution and By-Laws for consideration and action:

### AMENDMENT TO BY-LAWS OF STATE MEDICAL ASSOCIATION

BE IT RESOLVED, that Chapter VIII, Section 1, of the By-Laws be amended to read as follows:

*Section 1.*—The standing committees shall be as follows:

The Executive Committee.

Board of Appeals on Patient-Physician Relations.

A Committee on Convention Arrangements.

A Committee on Conference of County Medical Society Officers.

A Committee on Scientific Work.

A Committee on Scientific Exhibits.

A Committee on Public Policy and Legislation.

A Committee on Publicity.

A Committee on Industrial Health.

A Committee on Medical Education and Hospitals.

A Committee on Public Relations.

A Committee on Constitution and By-Laws.

A Committee on Rural Health.

The members of such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

In making such elections or appointments next after the effective date of the amendment the terms of such member shall be as follows:

If a committee consists of an even number of members, one-half shall be appointed for two year terms, and one-half shall be appointed for one year terms.

If a committee consists of an odd number of members, the majority by one shall be appointed for two years and the remainder for one year terms.

Thereafter all members shall be appointed for two year terms. All members shall serve until their successors have been elected or appointed.

BE IT FURTHER RESOLVED, that Chapter IX.—*Special Committees*, be amended to read as follows:

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

The terms of the members of such special committees shall be as heretofore provided for the terms of the members of standing committees.

5. *Preceptorship program.* Dr. Bibler, chairman of the Committee on Preceptorships of the state

association, reported on the April 12, 1954, meeting of his committee with the Executive Council of Indiana University School of Medicine, at which time Dr. Grey Dimond gave an excellent outline of his work in the University of Kansas School of Medicine. He also reported that 28 physicians have volunteered to participate in the preceptorship training program which probably will start with the fall term of school, and asked that the councilors report to him or members of the Preceptorship Committee the names of physicians in their communities who are interested in the preceptorship program.

#### 6. *Veterans affairs.*

(1) *Regional meeting.* Dr. Hayes, chairman of the Council Committee on Veterans Affairs, told of the regional meeting called by the AMA Veterans Affairs Committee and held in Indianapolis on March 20 and 21, 1954, with representatives from Kentucky, Illinois, Michigan, Wisconsin and Ohio in attendance, to disseminate information on and to discuss the problem of non-service connected disabilities of veterans, saying the AMA feels that this should be first, an educational program for physicians, and then whenever the time is right the information should be carried to the lay public. Drs. Glock and Nafe also discussed this subject.

(2) *VA contract.* Dr. Garner, chairman of the Committee on Veterans Affairs and Rehabilitation of the state association, called attention to the fact that the contract covering medical care and treatment to beneficiaries of the Veterans Administration was due for renewal for the period July 1, 1954 to June 30, 1955. On motion of Drs. Garner and Bibler, the Council authorized Dr. Garner to sign the contract now in existence with the Veterans Administration.

7. *Public relations program.* Dr. Mericle, chairman of the Committee on Public Relations, and the executive secretary reported that the committee had employed Keeling and Company, of Indianapolis, to handle the public relations program for 1954. The committee proposes to use a series of 1-minute spot announcements four times a week for 13 weeks. Effort will be made to inform the public on advantages of:

- (1) Getting acquainted with family physician;
- (2) Discussing fees in advance of treatment;
- (3) Emergency call services.

Money permitting and time being available, the committee also proposes to sponsor two 5-minute TV shows a week for 13 weeks, with film which has been approved and sponsored by the AMA.

Following discussion by Drs. Olson, Bibler and Glock, on motion of Drs. Myers and Bibler, the Council approved the program, methods and activities of the Public Relations Committee.

### 1954 Annual Session, Indianapolis, Monday, Tuesday and Wednesday October 25, 26 and 27, 1954

*Program.* The executive secretary reported that the Scientific Work and Entertainment Committees plan to have all arrangements completed and the program in final form by the time of the July Council meeting.

#### Legislative Matters

1. Drs. J. William Wright, Sr., and Hugh A. Kuhn, co-chairmen of the Committee on Public Policy and Legislation, discussed the several matters which probably will come up for consideration of the 1955 state legislature.

2. In the absence of Dr. A. G. Blazey, chairman of the Council Committee on Public Policy and Legislation, Dr. Topping read the following report from that committee:

#### *"The National Issues:*

"1. The Bricker Amendment is still the major issue on our national legislative agenda despite being attenuated by the George Amendment whose main purpose was to permit continued discussion in the House where the necessary amendments could be restored to actually protect our domestic government from the invasion of foreign socialist ideology. The parliamentary motion of Senator Lennon will allow the amendment to be voted on again in the Senate at the current session. Your continued efforts to request passage of the George Amendment is imperative.

"2. Next in importance is the Curtis Bill (HR 6863) and the Reed Bill (HR 7199) which would extend social security coverage, by force, to 6.5 million persons, leaving about 4 million preachers and government workers the privilege of accepting voluntarily.

"We fought the extension to 10 million domestic and farm workers in 1951 because the plan is fallacious, and nothing more than a form of socialistic redistribution of income. We lost.

"Now we are faced with the inevitable extension that will ensnare our profession. *Medical Economics* claims that about 50% of physicians polled are in favor of this socialistic scheme. I am confident that a poll of the members of the I.S.M.A. would dispel such propaganda. Yet we are being docilely inducted without adequate remonstrance.

"3. The next great national issues are the Smith-Wolverton Bills (S. 3114 and HR 8356) which would establish another federal corporation to trespass in the field of private enterprise by the establishment of a federal re-insurance corporation at a stipulated appropriation which would



be but a fraction of the actual costs. This new corporation would extend insurance to actuarially bad risks by additional federal taxation. It would put the ultimate direction of the plan under the new secretary of H.E.W. that our delegates to the A.M.A. sanctioned in March 1953. We fought Ewing and we conspired with Hobby. Now we pay the piper of both schemes.

"The other great national issues extending the tenacles of socialism into our body politic are: HR 6950 and 51 and 7700 by Congressman Charles Wolverton. These bills would provide an appropriation of 40 million dollars for long term loans to voluntary non-profit health associations for facilities and equipment, together with federal mortgage loan insurance for Kaiser and H. I. P. type health plans. Such legislative measures are totally outside of the realm of the Republic-type of government established by our federal Constitution. It is not the business of such a federal government to usurp state and individual rights in this manner. It is only the business of a collectivist type of government. Shall we protest—or shall we remain silent?

A. G. BLAZEY, M.D.  
W. U. KENNEDY, M.D.  
M. C. TOPPING, M.D."

#### New Business

1. *Remission of state dues.* On motion of Drs. Olson and Miller, the Council voted to remit the 1954 state dues of a member of the Vigo County Medical Society and also of a member of the Indianapolis (Marion County) Medical Society, both of whom have retired from practice because of ill health.

2. *Medical School curriculum.* Dr. Dudding called attention of the Council to the fact that the course in "Medical Economics" offered by the medical school for several years had been dropped from the curriculum and asked that the Council "consider some action which might suggest to the school that something of that nature be re-instituted."

The chairman referred this matter to the Council Committee on Educational Affairs, including

Postgraduate Study and Preceptorships, Dr. Wemple Dodds, chairman, for investigation and report to the next meeting of the Council.

3. *Nominations for Editorial Board.* Dr. Bibler nominated Dr. Keith Hammond (general practice) of Paoli, and Dr. Irvin W. Wilkens (internal medicine) of Indianapolis. Any further nominations are to be sent to Dr. Kennedy, chairman of the Council Committee on Miscellaneous Business.

4. *Complimentary subscription to The Journal for senior members.* Dr. Glock read the following communication, which, on motion of Drs. Bibler and Glock, was referred "to the Editorial Committee or whatever committee it takes, for study and report back to the next meeting of the Council with recommendations":

"April 19, 1954

"The following resolution was passed unanimously at the April 6th meeting of the Board of Trustees for the Fort Wayne Medical Society: "Be it resolved, that the Councilor for the 12th District, be asked to investigate the possibility of all Senior members of the Indiana State Medical Association receiving a free subscription to THE JOURNAL of the Indiana State Medical Association."

"Since, in many instances, this would be the only scientific Journal received by the Senior members, we believe that it should be the responsibility of the State Association to furnish the subscription rather than the county society."

Respectfully submitted,  
C. H. WARFIELD, M.D.,  
Secretary of the Board."

This was later referred to the Council Committee on Miscellaneous Business, Dr. W. U. Kennedy, chairman.

5. *Summer meeting of Council.* By consent, the next meeting of the Council will be held on Sunday, July 25, 1954, at the Indiana University Student Union Building, Indianapolis.

There being no further business, the meeting was adjourned.

## RADIO NETWORK TO CARRY AMA INAUGURATION

For the fifth consecutive year the installation of a new President of the American Medical Association will be broadcast nationwide by radio on Tuesday night, June 22, from the 103rd Annual Meeting in San Francisco.

Approximately 340 stations of the American Broadcasting Company radio network will carry the half-hour inaugural ceremony at which Dr. Walter B. Martin of Norfolk, Va., will become the Association's 108th President. The program, originating from the Gold Ballroom of the Palace Hotel, will be heard at 7:30 p.m., Pacific Coast Daylight Time (9:30 p.m. Central Daylight Time).



## District Meeting Reports

### Fourth Councilor District

The Fiftieth Annual Fourth District Medical Assembly was held in the Seymour Country Club May 5 with 98 members and guests registering. A golf tournament was held during the morning with official registration beginning at noon. Luncheon was served at 12:30. Golf prizes were awarded at this time and a number of guests introduced. Dr. Walter L. Portteus, president-elect of the Indiana State Medical Association, spoke at the luncheon discussing several current topics of interest to the profession and expressing some personal views.

Following the delegates meeting at which Dr. William C. McConnell, Sunman, was named president; Dr. J. C. Elliott, Guilford, vice-president; and Dr. G. S. Row, Osgood, secretary-treasurer, a scientific program was presented.

Dr. G. H. Kamman, Seymour, spoke on "50 Years of Medicine in the Fourth District";

**Children of Seymour and Brownstown physicians presented a style show for the wives of members attending the Fourth District Medical Assembly in Seymour May 5. In the first row, left to right, are Jane Ripley, Susan Black, Barbara Wiethoff and Barbara Ripley. Second row: Debbie Black, Jerry Shields, Nancy Martin and Janet Wiethoff.**



Dr. Rudy F. Vogt, associate professor of obstetrics and gynecology, University of Louisville, presented a paper on "Treatment of Common Complications of Pregnancy"; and Dr. Frank B. Ramsey, associate professor of surgery, Indiana University School of Medicine, spoke on "What Should a Patient with Cancer Be Told?" A discussion period and social hour followed.

The 1955 meeting will be held in Batesville on May 4.

The Woman's Auxiliary met on the same day for a program which included golf, cards, a tour of the Central Pharmacal Company and the Seymour Woolen Mills, a style show, luncheon and the late afternoon social hour with the doctors.

### Sixth Councilor District

A scientific program dealing with three aspects of arthritis highlighted the annual meeting of the Sixth District Medical Society in the Elks Club, Shelbyville, April 28.

"The Medical Aspect of Arthritis" was discussed by Dr. James S. Browning, Indianapolis; "The Pediatric Aspect of Arthritis" was presented by Dr. I. Winfield Scott, Indianapolis; and "The Orthopedic Aspect of Arthritis" was handled by Dr. Palmer Eicher, also of Indianapolis.

A golf tournament was enjoyed at 9 o'clock with the business meeting following at 11.

New officers elected to succeed Dr. Robert W. Kuhn, president; Dr. John E. Fisher, vice-president; and Dr. William R. Tindall, secretary-treasurer, are Dr. Fisher, New Castle, president; Dr. Tindall, Shelbyville, vice-president; and Dr. Charles E. Sheets, Manilla, secretary-treasurer. Dr. Walter U. Kennedy, New Castle, is district Councilor. The next district meeting will be held at Brookville, April 27, 1955.

Seventy-seven members and guests were



registered for the luncheon at which Dr. Kennedy, Dr. Harry P. Ross, Richmond, James A. Waggener, I.S.M.A. executive secretary, and L. E. Converse, Blue Cross, all spoke briefly. Dr. Walter L. Portteus, Franklin, president-elect of Indiana State Medical Association, was a special guest and luncheon speaker.

The District Woman's Auxiliary also met, holding the business meeting at 11 a.m., and joining the doctors for luncheon. The afternoon was spent playing bridge and canasta.



Pictures taken at Sixth District Medical Society meeting at Shelbyville show (left to right and top to bottom): Drs. Kennedy, Tindall, Fisher, Kuhn, Sheets and Plummer, district officers; Drs. Whitecomb, Endicott and Hunter; Dr. Frank Green; Drs. Dalton and Kuhn; Dr. Portteus; Dr. Charles Titus; Drs. F. B. Mountain and W. A. Thompson. Drs. Titus and Thompson are senior members.



# News from the County Societies

A panel of Fort Wayne doctors discussed "Diabetes Mellitus" at the April 6 dinner meeting of the **Fort Wayne (Allen County) Medical Society** in the Chamber of Commerce. Sixty-nine members heard Drs. B. M. Edlavitch, Julian Kaufman; Richard N. Kent and Karl R. Schlademan present the scientific program.

On May 4 the Fort Wayne Society honored 18 senior members of the society at a Senior Member Night program in the Chamber of Commerce. Following the dinner Dr. Bronson Ray, Cornell University, Ithaca, New York, spoke on "Evaluation of the Sympathetic

Nervous System and Operation on It." The special program attracted 135 members and guests.

No regular meetings of the society will be held until September 7 when the group will meet for dinner in the Chamber of Commerce.

Dr. Philip Rothrock, Lafayette, spoke on "Hypertension in General Practice" at a meeting of **Carroll County Medical Society** held April 21 in Friendship House, Delphi. Fifteen members attended the dinner meeting. Announcement was made that the county society would meet at the 11th District meeting at Marion on May 19.

**Dr. Charles Manley, Rising Sun, makes final entries on the secretary's book of the Dearborn-Ohio County Medical Society. He plans to leave for Cincinnati soon for special study.**

**Drs. O. H. Stewart, Aurora, and F. A. Streck, Lawrenceburg, listen closely as a member of the Dearborn-Ohio society discusses location of a new county hospital.**



A noon meeting of the **Daviess-Martin County Medical Society** was held at the Daviess County Hospital April 5 with 14 members present. Dr. A. G. Blazey, Washington, reported on the regional meeting of AMA held in Indianapolis recently and Robert Amick, ISMA field representative, discussed a number of subjects of an organizational nature. A brief hospital staff meeting followed after which the group viewed a film on "Intra-Articular Injections with Hydrocortisone."

At the May 5 meeting of the Daviess-Martin society Dr. M. H. Seat, Washington, gave a paper on "Rheumatic Fever" with an interesting discussion period following. Robert J. Amick spoke on Indiana State Medical Association activities and stressed the wire and tape recordings and recorder service now available through the headquarters office. Fifteen members attended the noon luncheon program in Daviess County Hospital.

**Dearborn-Ohio Medical Society** members met at the Dearborn Country Club for a dinner meeting April 15 with 10 present. A general discussion about local matters followed. Announcement was made by Dr. Charles N. Manley, Rising Sun, that he was reducing his practice to a part-time basis May 1 and soon would leave Rising Sun for



Cincinnati to accept a residency. After some discussion the society went on record seeking an early agreement on location of a new county hospital. Dr. Fred Houston was elected secretary to replace Dr. Manley.

A paper on "Observations on Convulsive Seizures—Infants to Adolescence" given by Dr. Charles Overpeck, Greensburg, before members of the **Decatur County Medical Society** April 20 was reported to have been well received. The noon luncheon meeting was held in Decatur County Hospital, Greensburg, with 8 members present. Various local medical problems were discussed, including the request for approval of a chest X-ray as part of routine hospital admission. A committee was appointed to study this matter.

Forty-five members attended the April 20 meeting of **Delaware-Blackford County Medical Society** in the Delaware Hotel, Muncie, when a varied program was offered including a panel from the Muncie Chamber of Commerce, which discussed the organization's operation and program; a discussion of the public relations program of the Indiana State Medical Association and the availability of tape recordings through the State headquarters office by Kenneth Bush, field secretary; a report from Dr. E. H. Clauser on his recent trip to New York for participation in the Blue Shield meeting; and a general discussion of progress being made on the project of holding a series of Medical Forums in Muncie. The next meeting of the group was to be held May 18, one day before the district meeting.

Dr. John H. Barrow, Dale, was the guest speaker at the **Dubois County Medical Society** meeting held in Mullis Tourist home, Ferdinand, April 8. He discussed "Distribution of Physicians and Public Relations." Twelve members of the society attended and were joined for dinner by members of the Auxiliary. At his request Dr. Barrow was voted into active membership. The next meeting of the society will be held June 10 in Jasper.



Two groups of Elkhart County Medical Society members are pictured at a recent dinner meeting. Above, left to right, Drs. Page E. Spray, secretary-treasurer; Edward G. Neidballa, president; Waldo J. Lehman; Hampar Kelikian, Chicago, guest speaker; and Lloyd O. Rupe. Below are, left to right, Drs. William M. Stubbins and Bruce A. McArt, and another guest, L. E. Converse, in charge of physician relations for Blue Shield.

**Floyd County Medical Society** members held a general business meeting following dinner in the New Albany Country Club April 9. Decision was made to have one meeting each year devoted entirely to discussion, eliminating any program. Twenty-one members attended. Robert J. Amick, field secretary, spoke about the annual convention of Indiana State Medical Association, several legislative matters pending in Washington, and the 1955 session of the General Assembly.

Dr. V. Logan Love, Marion, gave a scientific talk on "Veins" at the April 22 meeting of **Grant County Medical Society** in the Hostess House, Marion. Members later discussed a proposed organization of a visiting nurses plan for Marion and decided to endorse and

actively promote the project. The medical society meeting was well attended. Members of the Woman's Auxiliary met at the same time and place for a dinner meeting.

**Greene County Medical Society** met April 15 for a 7 o'clock dinner meeting in Linton and later heard Dr. M. S. Fox, Vincennes, speak on "Allergies of Interest in General Practice." The 18 members present then discussed establishment of a blood bank and voted to go ahead with the project. The next meeting was scheduled for May 13 in Freeman Green County Hospital, Linton.

A noon luncheon and general business meeting of **Hendricks County Medical Society** was held in the O. K. Restaurant, Danville, April 13 with 11 members attending. Dr. M. O. Scamahorn expressed thanks on behalf of the society to the staff of I.S.M.A. for information recently secured for him and was followed by Robert Amick, field secretary, who gave de-

tails of the trip to the AMA convention, plans for the 1954 meeting of I.S.M.A. in Indianapolis, and the library of tape recordings now available from state headquarters.

Dr. Dwain N. Walcher, Indiana University Medical Center, Indianapolis, was the guest speaker at a March 18 meeting of **Henry County Medical Society** in the Henry County Hospital, New Castle. He spoke on "Infectious Diseases of Children" before the 16 members present. The meeting was held at 8:45 p.m.

The entire evening was used to plan mass inoculation of grade school children with the Salk vaccine when the **Howard County Medical Society** met for a 6:30 dinner at the Frances Hotel, Kokomo, April 6. Twenty-four members and five guests attended.

Sixteen members of **Huntington County Medical Society** met April 6 in the Moose

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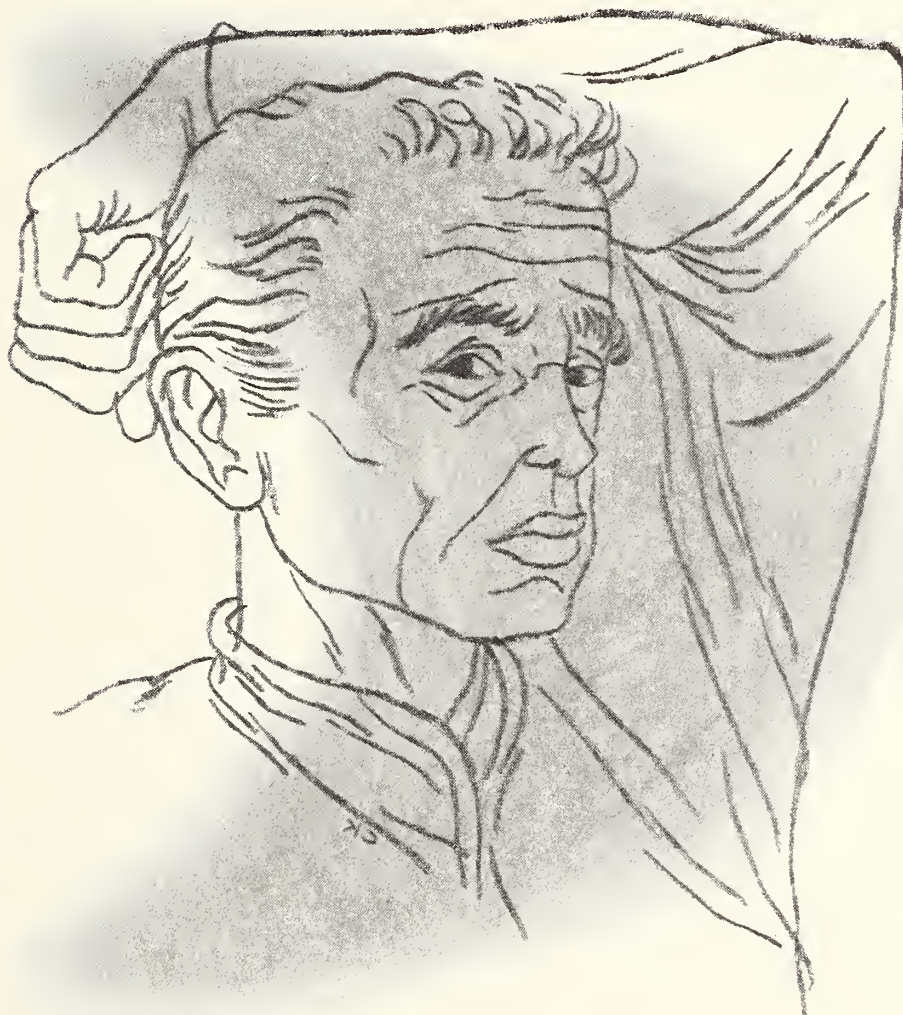
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1. Gurdjian, E. S., and Webster, J. E., *Amer. J. of Surgery*, 63:236, 1944.



Lodge, Huntington, for dinner and a program furnished by a Red Cross discussion group. The May meeting was scheduled for the Hostess House, Marion.

**Jackson and Jennings County Medical Society** members held a dinner meeting April 16 in the Elks Club in Seymour. Sixteen attended. Dr. W. B. Sigmund, assisted by Dr. David Adler, both of Columbus, presented a paper on "TB of the Urinary Tract."

R. J. Amick, field secretary, told the group of a number of services available to them as a group or to individual doctors through the Indiana State Medical Association, and discussed a number of current projects of importance to the medical profession.

At the March 19 meeting of the same groups held in Seymour, Dr. Robert Jenkins, Indianapolis, presented a paper on "Dermatology of the Hands," which was followed by a question and answer period which required more time than the presentation of the paper.

Twenty-three members of **Knox County Medical Society** met in the Orchard Room of the Grand Hotel, Vincennes, April 13 for a dinner meeting. No formal program was arranged.

"Neuro-Surgical Problems from the Standpoint of the General Practitioner" was the title of a paper presented by Dr. Harold C. Voris, clinical professor of neuro-surgery at Loyola Medical School, Chicago, before a joint meeting of the **LaPorte and Porter County Medical Societies**. Fifty members attended the meeting which was held in Beatty Memorial Hospital, Westville, April 15. Dinner was served preceding the scientific and business meetings. The LaPorte County Society has voted to present a series of Medical Forums for the public next fall and winter. The last meeting of the LaPorte society until fall was scheduled for May 21.

Thirty-nine members of **Madison County Medical Society** attended a meeting April 19 in the Anderson Country Club when Dr. John P. Graf, South Bend, spoke on "Anesthetic Emergencies—Care of the Unconscious Patient." Favorable action was taken on the transfer of Dr. J. W. Hammer, Jr., Middletown, from the Delaware-Blackford County Medical Society to the Madison society. The next scheduled meeting was also a dinner meeting in the Anderson Country Club on May 17.

Dr. Henry S. Tanner, Indianapolis, spoke on "Orthopedic Problems in General Practice" at the April 15 evening meeting of the **Montgomery County Medical Society** in Culver Union Hospital, Crawfordsville. Twenty-one members attended. A short business meeting was held. The next meeting of the society will be held June 17 at the hospital.

**Parke-Vermillion County Medical Society** met April 21 in the Vermillion County Hospital, Clinton, with Dr. H. B. Pirkle, Rockville, as guest speaker. The topic of his paper

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### SUGGESTS GADGET EXHIBIT

A "gadget" exhibit has been suggested for the October convention of Indiana State Medical Association by Dr. Walter L. Portteus, Franklin.

The idea was referred to the Scientific Exhibits Committee which will be interested in such an exhibit if there are sufficient contributors.

If you have some instrument which facilitates your work, if you have some gadget which has proven handy, if you have some aid for physicians' offices or some record plan, and are willing to have it exhibited, will you please notify Dr. J. L. Arbogast, Indiana University Medical Center, Indianapolis 7, Indiana, chairman of the Scientific Exhibits, so that such an exhibit can be planned?

Do it now!

was "Cancer of the Lung." Thirteen members attended the dinner meeting. The May meeting of the society was replaced by the Fifth District meeting. Next meeting of Parke-Vermillion doctors will be held September 15 at a place to be determined.

**Perry County Medical Society** held a business meeting in the office of the Perry County nurse in Cannelton April 6 with 9 members present. A number of organizational subjects were discussed with R. J. Amick, field secretary, and a special committee which recently met with the I.S.M.A. Executive Committee.

**Wabash County Medical Society** has reported meetings held for the first quarter of 1954 as follows: January 13, dinner and business meeting at Sheller Hotel, North Manchester, with 13 present; February 10 in the Honeywell Memorial Center in Wabash when 10 members heard Blue Cross representatives discuss various aspects of hospitalization insurance; and March 10 in the Sheller Hotel, North Manchester, with Dr. A. N. Ferguson, Fort Wayne, presenting a paper on "Angina Pectoris" to 14 members.

Dr. Robert W. Schimmelpfennig, Marion, was guest speaker at the April 14 meeting of the Wabash society held in Honeywell Memorial Center. He discussed "Pulmonary Hyaline Membrane Disease in Infants." Fourteen members attended the dinner meeting. The May 12 meeting was also scheduled for the Honeywell building.

Consideration of organization of the staff of White County Memorial Hospital was given priority at the business meeting of **White County Medical Society** held April 14 in Holiday Inn, Monticello. Seven members were present for the dinner and business meeting. Their next meeting will be on July 13.

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### EDITORIAL AND ADVERTISING INFORMATION

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Photographs should be printed on glossy paper. Negatives cannot be used.

Only a limited number of illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

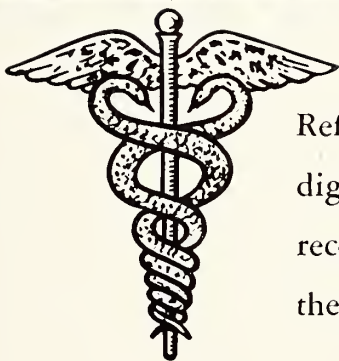
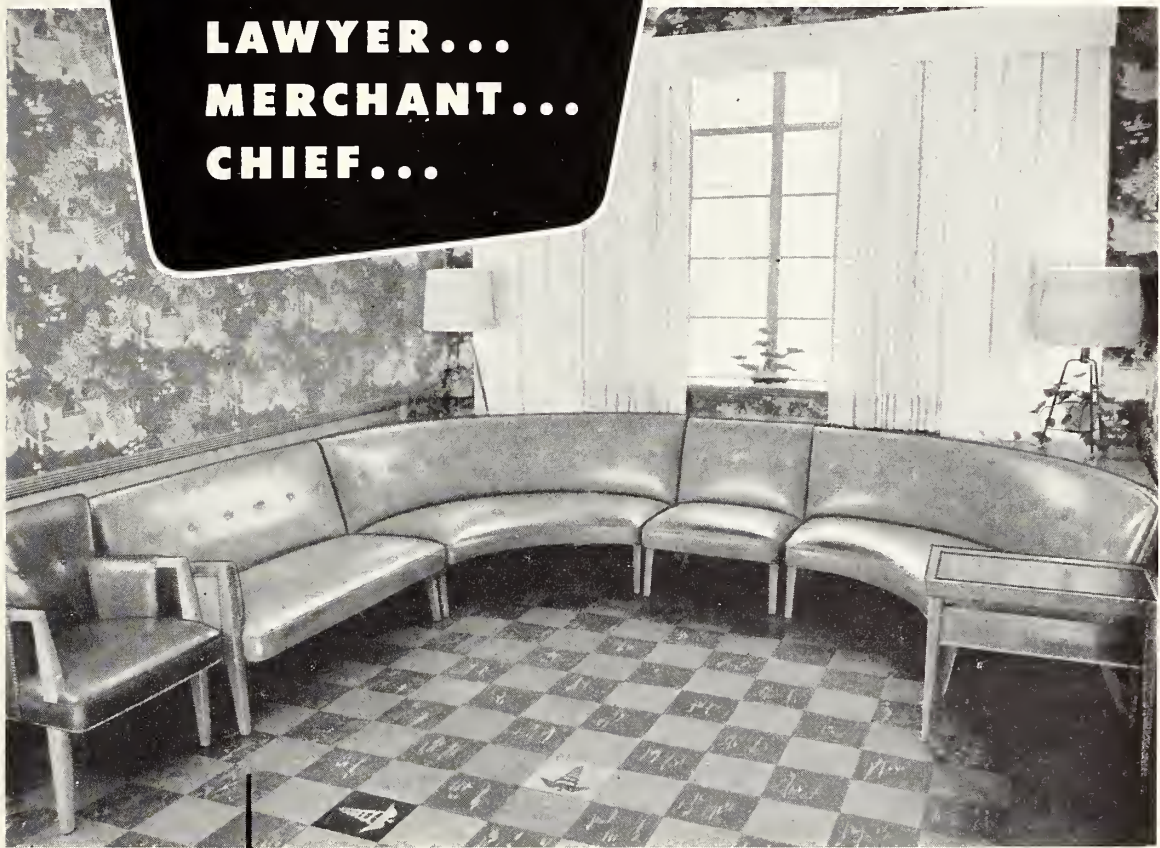
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# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## ABOUT OUR DOCTORS

We noted with interest recent letters from readers in the public forum of this newspaper commending both local hospitals and doctors. Since this is National Hospital Week, we think it is well that recognition again be given our hospitals for the excellent manner in which both those institutions are operated.

It is also only proper that the doctors of this community be given some credit, for they are not only responsible for the level and caliber of medical care, but also have much to do with the standard maintained by both hospitals.

While doctors in general have on occasion been much-maligned as a group, blanket criticism of any group is rarely justified, whether that criticism be leveled at veterans, Republicans, Democrats, or doctors. Certainly there are doctors who have been guilty of unethical actions and undesirable practices, just as there are some members of every group who are not what they should be. But Logansport is fortunate in having a group of doctors, the majority of whom are able, sincere, and available at reasonable and often unreasonable times.

From comments heard, it seems that the question of availability of doctors is most misunderstood. We as individuals take our leisure time for granted. When vacation comes, most of us go. We attend social affairs or shows in the evening without interruption. We're not routed out once or twice in the middle of our night's sleep. We can attend church and remain for the complete service. We can enjoy whatever time we want with family and friends. Yet many of us, as patients, forget that our doctor too is a normal individual who not only enjoys a little leisure and relaxation but who by the very nature of his work actually needs that

relaxation in order to competently perform his duties.

Doctors frequently use their vacations to attend school or medical meetings to keep abreast of all new developments in their field. Many doctors quickly forego planned trips to stay in town to take care of known emergencies and expected births. As a general rule, most all doctors keep their schedule flexible enough to take care of their patients. Many Wednesday afternoons "off" are occupied with calls.

Admittedly, the nature of the medical profession requires a necessary irregularity and sacrifice, as well as the compensations involved, all of which most doctors recognize. The public, however, can aid themselves and their doctors by permitting the doctor to fulfill a little better his duties to his family and himself through a few simple considerations: whenever possible, see the doctor only in his office, where he can take better care of you and has the facilities readily available; unless it is a real emergency, do not demand that he come in person immediately. Sufficient advice can frequently be given by phone; try not to call him after regular hours unless it is absolutely necessary. When you do call him, calm yourself so that you can answer his questions simply and intelligently; likewise, a little humbleness goes a long way.

If it is impossible to reach your own doctor, you can, in a real emergency, reach a doctor 24 hours a day for personal attention or telephone advice, by phoning either of the two local hospitals.

Most doctors fully recognize their responsibilities. They are stable citizens of the community, and provide us that feeling of security which comes in knowing that help is available when we most need it. With a little thought and consideration on the part of each of us, we can do much to help them do an even better job.

—Logansport Pharos Tribune

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The folder, which is concise and simply worded, is now available to physicians, hospitals, and others in the health field for use during the polio season. Supplies may be secured without charge from The National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

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Supervised by THE COUNCIL

Volume 47 — July 1954 — Number 7

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## RECORD NUMBER OF PHYSICIANS LICENSED IN 1953 TO PRACTICE MEDICINE

*A*N ALL-TIME RECORD NUMBER of physicians—218,522—were licensed to practice medicine in the United States at the close of 1953, it was disclosed in the 52nd annual report on medical licensure of the American Medical Association's Council on Medical Education and Hospitals.

Of this total, 156,333 were engaged in private practice, 6,677 were engaged in full-time research and teaching and were physicians employed by insurance companies, industries, and health departments, 29,161 were interns and residents in hospitals and those engaged in hospital administration, 9,311 were retired or not in practice, and 17,040 were in government service.

According to the report, during 1953 there were 14,434 licenses to practice medicine issued by the 48 states, the District of Columbia, Alaska, Canal Zone, Guam, Hawaii and Puerto Rico—an increase of 1,206 over the number issued during 1952 and the third largest number issued in the history of this country. Of this total, 6,565 were granted after written examination and 7,869 by reciprocity or endorsement of state licenses or the certificate of the National Board of Examiners. The majority of those

issued by reciprocity or endorsement were to already licensed physicians who moved their practice from one state to another.

The data presented in the report showed that last year 7,276 physicians received their first license to practice medicine. In the same period there were approximately 3,421 deaths of physicians reported, so that there was a net gain of 3,855 in the physician population in the United States and its territories and outlying possessions. During 1952, there was a net gain of 2,987.

### California Leads States

The greatest number of licenses issued in 1953 was granted by California—1,977. New York was second with 1,348 and more than 500 physicians were registered in Illinois, Ohio, Pennsylvania and Texas. Less than 50 licenses were issued by Nevada, Delaware, Idaho, Montana, New Hampshire, North Dakota, South Dakota, Vermont, and Wyoming.

From 1935 through 1953, a total of 207,744 licenses to practice medicine was issued in the United States. During the same period there were 119,510 additions to the medical profession

—an increase reflecting accelerated programs in medical schools, expanded facilities, and the licensure of foreign trained physicians.

The excellent rating of the nation's and Canada's approved medical schools was pointed up by the number of applicants who successfully passed examinations. Thirteen per cent of the total number of applicants who took written examinations for licensure failed, the report stated. Only 3.8 per cent of the graduates of approved medical schools in the United States and 4.1 per cent of those of approved Canadian medical schools failed. In contrast, 50 per cent of those graduated from now extinct medical schools in the United States failed, as did 45.5 per cent of

The number of graduates of foreign faculties of medicine examined began increasing in 1936, and by 1940 there were over three times as many tested as in 1936, according to the report. Beginning in 1944 the numbers examined began to decrease until 1951, when there was a noticeable increase, an increase again recorded in 1952 and 1953.

### Many Foreign Graduates Fail

During 1953, 1,463 graduates of 175 foreign medical schools and seven licensing corporations of foreign countries were examined by 36 licensing boards. A total of 796 successfully passed the examinations; failures numbered 667, or 45.5

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Indiana issued 306 licenses to practice medicine in 1953. Of the total 162 were granted following examination and 144 by reciprocity or endorsement. Two graduates of approved Canadian schools were examined in the state and licensed.

During 1953 examinations were given 158 graduates of Indiana University School of Medicine in 10 states. Three applicants for licenses failed; 155 were licensed. Percentage of I. U. graduates failing was 1.9% as compared to the national average of 3.8%.

Geographically, the east north central region, composed of Ohio, Indiana, Illinois, Michigan and Wisconsin added the largest number of licensed doctors to the profession—1,655. In Indiana total gain for the year was 163.

The national report also disclosed that 47 licenses had been issued to osteopaths in Indiana during the last five years.

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the graduates of foreign medical faculties, 70.2 per cent of graduates of unapproved U. S. medical schools no longer in existence, and 13.4 per cent of graduates of schools of osteopathy.

The current report on medical licensure revealed that in many states the licensure of foreign trained physicians has been given serious consideration by the authorities and that methods are being developed to provide for the licensure of such physicians which will not lower the standards of medical practice in the United States.

However, the report stated, the Council on Medical Education and Hospitals of the A.M.A., the Association of American Medical Colleges, the Federation of State Medical Boards, and other interested agencies now are engaged in discussions looking toward a re-evaluation of the problem created by the influx of foreign trained physicians migrating to the United States to pursue their profession.

per cent. At no time during the last 24 years did fewer than 30.7 per cent of such graduates fail in a given year, it added.

"This extremely high percentage of failures is a primary factor in the cautious attitude that has been maintained by licensing boards in admitting foreign graduates to the licensing examination," the report said.

The largest number of foreign graduates were examined by New York—450; Illinois examined 411, California 148, and Ohio 105. Foreign trained physicians may apply for licensure to all but 11 licensing boards, according to the report. Most of the boards have stipulations which must be complied with prior to licensure examination.

The report, which appeared in the May 29 Journal of the American Medical Association, was prepared by Dr. Edward L. Turner, secretary of the Council on Medical Education and Hospitals of the A.M.A., and Mrs. Anne Tipner, assistant to the secretary.

## PREGNANCY OUTCOME AFFECTED BY ATOMIC RADIATION, SURVEY INDICATES

**R**ADIATION from the atomic bomb explosion over Nagasaki, Japan, in 1945 had considerable effect on the outcome of pregnancies of women in the city who were pregnant at the time.

Among 30 pregnant women with major signs of radiation injury, there were three miscarriages, four stillbirths, three babies who died within the first month of life, three infants who died within the first year of life, and one who died at two and one-half years. Four of the surviving 16 children were mentally retarded.

Drs. James N. Yamazaki, Stanley W. Wright and Phyllis M. Wright, Los Angeles, found this evidence in a study of pregnant women exposed to the atomic blast at Nagasaki and their offspring. Their report appears in the *American Journal of Diseases of Children*, published by the American Medical Association.

The pregnant women studied were divided into two groups—98 who were within the radiation area, 30 of whom showed what the physicians termed major radiation injury signs, and a control group of 113 pregnant women who were outside the radiation area of the city at the time of the bombing.

The over-all morbidity and mortality of the outcome of pregnancy among the 30 women who suffered major radiation injury signs was approximately 60 percent, as compared to 10 percent among the 68 other pregnant women within the radiation area, and about six percent among the 113 women outside the radiation area, the doctors stated.

In the group of 68 women who were within the radiation area but sustained no major signs of radiation injury, there was one miscarriage, two stillbirths, three babies who died within the first month of life, and one case of mental retardation.

### Children Retarded

In the control group of 113 pregnant women outside the radiation area, there were two miscarriages, one stillbirth, one baby who died within the first month of life, and three infants who died within the first year of life.

In addition, the study disclosed that children born to mothers with major signs of radiation injury were retarded in growth and development, the doctors stated. These children were significantly smaller in height and head circumference than those children born to mothers in the control group.

"It is difficult to evaluate the effect of radiation on this mortality and morbidity, since other factors, such as trauma, burns, infections, etc., may have a deleterious effect on the fetus," the doctors stated. "The evidence strongly suggests, however, that radiation, either directly to the fetus or indirectly as a result of its effect on the maternal tissues, was of considerable importance in determining the outcome of these pregnancies."

The physicians are associated with the Laboratories of the Atomic Bomb Casualty Commission, Hiroshima, Japan, and the Department of Pediatrics, University of California Medical Center.

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CHILDBIRTH. Today, a woman has better than 999 chances out of 1,000 of coming through childbirth safely, according to the American Medical Association. A woman's chances of surviving childbirth are eight times better than were her mother's.



## USE OF POLIOMYELITIS GAMMA GLOBULIN DURING 1954

A COMPREHENSIVE REPORT evaluating the use of gamma globulin during 1953 has been published in the *Journal of the American Medical Association*, volume 153; 13, March 27, 1954. The epidemiologists studying the use of gamma globulin have determined that it was little, if any, value in the mass immunizations that were conducted on a country-wide scale last year. In addition, no beneficial results were observed in any of the areas where detail studies were made following the use on familial contacts. As a result of these findings, agreements were made between the state and territorial health officers, the Office of Defense Mobilization, the American Red Cross and the National Foundation for Infantile Paralysis that the latter two volunteer agencies would furnish immune serum globulin for prophylaxis of poliomyelitis to the Office of Defense Mobilization during the calendar year 1954. These agencies agreed to furnish the gamma globulin for polio prophylaxis providing the state and territorial health officers and the Office of Defense Mobilization would distribute polio immune serum globulin for prophylaxis of polio in accordance with the following criteria:

1. Poliomyelitis gamma globulin to be used only in the inoculations of groups larger than single family units. (A neighborhood, apartment house, housing project, school, institution, camp or district within a community or entire community.)
2. The state health officer is charged with the determination of what shall constitute a group. He also must determine the time the group is to be inoculated, the area and size dose to be given.
3. The state health officer was mandated not to use gamma globulin where it would affect the validity of the vaccine field trials. The use of gamma globulin in the control of measles and infectious hepatitis does not come under these criteria.

**New Criteria for Immune Globulin for Polio for 1954 are:**

1. Globulin for polio prophylaxis will be distributed in accordance with the above agreements. The responsibilities of the state health officer in regard to gamma globulin distribution have been delegated to the director of communicable disease control, Indiana State Board of Health. All communications in regard to gamma globulin should be directed to

Albert L. Marshall, Jr., M.D., Director  
Division of Communicable Disease Control  
Indiana State Board of Health  
1330 West Michigan Street  
Indianapolis 7, Indiana

2. Polio gamma globulin is to be kept separate from that furnished for measles and infectious hepatitis and its issue is to be so recorded.
3. The word "group" will apply to those individuals under 30 years of age in boarding houses, rooming houses, summer camps, schools, church groups and groups determined by the health officer. The agreement was that the state health officer and/or his designates or associates should determine which groups received polio globulin and which did not. The state health commissioner has designated the local health officer of a community as the individual to determine which groups qualify for mass prophylaxis in his jurisdiction. In unusual or questionable cases, the local health officer will contact the Indiana State Board of Health.
4. Polio gamma globulin will be available to a maximum dose of 20 cc. for any case of pregnancy exposed to a case of polio. This prophylactic dose of polio globulin may be requisitioned by any physician upon the regular requisition form. (SBH 2-18-38

obtained from health officers, globulin depots or Indiana State Board of Health.)

5. The maximum individual dose to be given to any individual for polio prophylaxis is to be 20 cc.

#### Distribution:

1. Any physician may request prophylactic dose of gamma globulin for a case of pregnancy under his care that has been exposed to an active case of polio. Request form SBH 2-18-38 may be submitted to any of the depots listed in the May issue of *THE JOURNAL*. Inasmuch as the earlier the globulin is given, the more likelihood there is of it being of value, physicians are urged to send a member of the family of the patient to the depot to pick up the gamma globulin. None of the depots have had funds provided in their budgets to cover the added expense of mailing gamma globulin to the physicians. Inasmuch as the globulin is furnished without cost to the patient, it is felt that the patient or patient's family should make some effort in obtaining gamma globulin.

2. The local health officer and/or his designates or associates will determine if exposed individuals desire to be given gamma globulin. If so, and a group inoculation is planned, the local health officer must be furnished a list of names of the individuals exposed. The health officer, having jurisdiction, will requisition ample supplies of gamma globulin within the proposed dosages to administer to the group. The depot furnishing the gamma globulin shall then forward to the Indiana State Board of Health a copy of the request form SBH 2-18-40 showing the name of the primary case of polio, the number of individuals to receive the gamma globulin and the total amount of the material required. The health officer shall prepare a roster of persons on SBH 2-18-40A who will receive the gamma globulin indicating name, address, age, weight, sex and amount of gamma globulin given. The local health officer shall retain one copy for his file, forwarding the original to the Indiana

State Board of Health, Division of Communicable Disease Control.

3. Gamma globulin for polio prophylaxis will be packaged only in 10 cc. vials.
4. Because of budgetary requirements, the local health authority or his designates shall arrange for transportation of the necessary globulin. Each physician administering the globulin should send courier to health officer to pick up globulin he is going to administer.

#### SUGGESTED DOSAGES:

Maximum—20 cc. per individual  
Children up to 35 lbs.—6 cc.  
“ up to 62 lbs.—10 cc.  
“ up to 100 lbs.—15 cc.

**Use of Gamma Globulin in Counties Included in Polio Vaccine Validity Trials.** Although not actually prohibited from use, under the national gamma globulin allocation program for 1954, in the vaccine field trial study population, the recommendation has been made as follows: “Poliomyelitis immune globulin shall be used in areas selected by the state or territorial health officer and the National Foundation for Infantile Paralysis for a trial of the vaccine developed by Doctor Salk for the National Foundation for Infantile Paralysis, only where in the opinion of the state or territorial health officer, it will not affect the validity of the vaccine field trials. This does not affect the use of gamma globulin for the control of measles and infectious hepatitis and in unusual circumstances.” As the local health officer has been delegated responsibility for group inoculations, it is suggested county and city health officers in vaccine areas weigh carefully the decision regarding use of gamma globulin against polio in their jurisdiction.

Counties engaged in the polio vaccine validity trials have received additional information for the necessary records to be kept when in their counties gamma globulin is given to individuals who have received or are receiving the polio vaccine or who are included on the registration schedules of the control group. While it is recognized that this is additional record keeping, it should be clear that such information will be necessary to thoroughly evaluate the successfulness of the use of polio vaccine.

## A DOCTOR LOOKS AT ADOPTIONS

A. T. STONE, M.D.

*Indianapolis*

**T**HE BIRTH OF A BABY still remains a miracle. But what happens to that baby after its arrival is often a far call from the miraculous. The future of a baby born out of wedlock is especially precarious, and the role of the doctor in this situation is very important.

Adoption is a lifetime decision! The baby's future, the happiness of the foster parents, and the assurance of the natural mother that her baby is well provided for are all at stake.

A generation or two ago, the family doctor in a small closely-knit community knew, probably better than anyone else, all three sides of this problem. Intimately acquainted with his patients, his help was sought in such emergencies. He was able to solve the social problem of illegitimacy as well as the medical care of the pregnancy. Busy he was, but his area of activity was limited by the horse and buggy, and he saw the same people year after year, following their progress from infancy to maturity. This made him an ideal person to seek for advice and guidance in such circumstances.

Today the picture has changed. Modern transportation extending the area of his practice, the tremendous advances in medical science which demand that the doctor study constantly to keep abreast of new developments, all this has affected the position of the family doctor in relation to the adoption problem. With this in mind, let us look at the three sides of the problem again: the mother, the foster parents, and the baby.

The modern doctor, general practitioner or obstetrician, knows his people only as patients. He has little chance to learn their personal lives even if he has time. People do not stay put, they change homes, they change jobs, and they move from city to city and state to state. Moreover, the unmarried mother today is more likely to seek help outside her community than from her own family physician. So the doctor seldom

knows the intellectual or social background of the prospective adoptive baby.

Not only is it nearly impossible for the modern doctor to inform himself as to the background of the baby, but also it is equally difficult for him to evaluate the prospective foster parents. The mere desire to have children does not automatically produce foster parents capable, financially or emotionally, of rearing children. The doctor has only a very limited opportunity to study them as people, and would immediately disclaim making any attempt to pry into their pasts or personal attributes beyond those pertaining to their physical well-being. He cannot evaluate their emotional stability on the basis of a few visits with them in his office, his church, or his club.

The evaluation of the baby's potentialities is equally difficult. The delivery of the baby is an important but a very brief contact between the doctor and this new individual. He sees this infant perhaps a half dozen times during its hospital stay. On physical examination at the time of its dismissal from the hospital, he cannot fully predict its physical or intellectual development. And if the adoptive parents live outside his particular clientele, he may never see it again. Final adoption proceedings at this point leave no recourse to the foster parents if the baby is defective or to the mother if she should change her mind about having the baby adopted.

Therefore some sort of interim care or custody is necessary for the protection of the foster parents and the natural mother. Reliable psychological tests are now in use which point out at an early age accelerated or retarded development. The natural mother on recovering from the physical disability of her pregnancy may view her problem in a different light. Therefore, such an interim period would safeguard the interests of all the parties to the adoption.



Finally, the baby itself needs more protection of its interests than the doctor has the time or opportunity to provide. A line from Ogden Nash seems pertinent at this point:

"The trouble with a kitten is that  
Eventually it becomes a cat."

Babies don't stay babies. They grow up rapidly and persistently. An experienced agency can recognize the signs of difficulty during the adjustment period and can intelligently guide and counsel the foster parents. In an extreme situation, the agency may need to seek other arrangements for the child's best interests. The

infant cannot protect himself. The community is responsible for its assurance of a future. Good but brief attentions by the family doctor are not enough.

Pleasant as it may be to the doctor to act as comforter to the distraught mother and as benefactor to the eager adoptive parents, the adoption problem is beset with too many pitfalls for him to play this role in our modern complicated civilization. It would behoove him more to assist the qualified child-placing agencies in his community in improving and expanding their services, so that adoptions will achieve happiness for all concerned.

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#### AN ABSTRACT:

**Gillespy, Thurman, Jr.: Inversion of the Puerperal Uterus,  
The West Virginia Medical Journal. 50:121-125 (May) 1954.**

Inversion of the puerperal uterus is a rare but serious obstetrical complication. It may be complete or partial. Its reported incidence varies widely, but is generally estimated once in about 25,000 deliveries.

The etiology of inversion of the uterus is unsettled. But most observers believe there is a congenital abnormal physiological factor of musculature and innervation, combined with mismanagement of the third stage of labor.

The diagnosis is not difficult. Hemorrhage occurs with profound shock and there is a globular bright red bleeding mass within the vagina or protruding from the vulva. It may occur after the placenta is delivered, or the placenta may still be attached to the uterus. A pedunculated submucous myoma may be confused with inversion of the uterus. In the latter condition the fundus is not palpated abdominally.

Most inversions can be prevented by avoiding traction on the cord and pressure on the atonic uterus. The lowest mortality is achieved when the uterus is immediately repositioned. Blood transfusion should be started at once. Replacement of the inverted uterus requires deep anesthesia. If immediate manual replacement is unsuccessful, the Spinelli operation, opening the abdomen and reinverting the uterus by traction by Allis forceps or hysterectomy will be imperative. Postpartum antibiotic therapy is obviously essential.

The incidence of recurrent inversion in subsequent labors is high. The author reports a case with profound shock out of proportion to the amount of blood lost. The uterus was immediately repositioned and the patient recovered.

## *Opinions From Here and There* (Continued)

(3) A third man who also became 65 in June 1952 and whose only covered employment occurred in the six quarters beginning in January 1951 earned just the minimum of \$50 each quarter required for coverage. The tax paid by himself and his employer would have been \$4.50 each, or a total of \$9. For this \$9 contribution he would have received benefits of \$20 each in July and August of 1952 and \$25 a month thereafter. With a 13-year life expectancy he could expect to receive benefits totaling \$3,890, or 432 times the \$9 contribution he and his employer together had made.

### **Discrimination Prevalent in Present Program**

Many features of the OASI law have weaknesses which result in favoring individuals or groups in certain circumstances and discriminating against others. Here are some examples:

Existing law denies the privilege of coverage to about 12,000,000 employed persons and at the same time requires participation of over 50,000,000 employed in covered industries.

Commercial fishermen employed on boats over 10 tons in size are covered but those employed on smaller boats are not covered unless they fish for halibut and salmon, in which case they are covered.

An individual who is employed on a bona fide basis, in otherwise covered employment, by a son, daughter or spouse is excluded from coverage although he would be covered if employed by an in-law, cousin or other relative. If over 21 years of age, he would be covered as an employee of a parent but would not be covered if under 21.

The retirement test favors the self-employed as compared to the wage worker. If a self-employed person and a wage earner continued to work after reaching age 65 and earned \$80 a month each, the wage earner would be denied his retirement benefit every month of the year because of monthly earnings over \$75, but the self-employed would lose his benefit for only the one month when his annual earnings exceeded \$900.

A person who became 65 in December 1950 and who had six quarters of covered employment at \$450 earnings each quarter during the period 1937-49 would now be getting a monthly benefit

of \$25. But another person who became 65 in June 1952 and had the same period of coverage and the same earnings beginning in January 1951 would get a monthly benefit of \$62.50.

A retired worker of 65 who was actively a part of the labor force since 1937 but who was never in covered employment is eligible for no benefits. If, however, he had worked as little as six quarters in covered employment immediately before retiring in June 1952 he would be eligible for monthly benefits of \$25 to \$85.

To a large extent the discriminations under present law stem from the incompleteness of coverage since the program started in 1937.

### **Changes in Social Security Law Now Being Considered**

Hearings on proposed amendments to the OASI portion of the Social Security Act have recently been completed by the House Ways and Means Committee. In addition to considering the proposals of the Administration as embodied in a bill (H. R. 7199) introduced by the Committee Chairman, Daniel A. Reed, the Committee has before it numerous other bills, most of which expand and liberalize the existing system as does H. R. 7199. One bill which makes a major departure from the present system is H. R. 6863, introduced by Representative Carl T. Curtis.

In certain respects the Reed (Administration) bill and the Curtis bill are similar. Both bills would extend coverage to over 10 million persons not presently eligible. This in future years would eliminate many inequities in present law. They would also equalize the retirement test between wage earners and self-employed by placing both on an annual basis of \$1000 permissive earnings before benefits are lost for any month.

The Reed bill increases benefits generally, raising all benefits at least \$5 a month. The minimum primary (worker's) benefit is raised from \$25 to \$30; the maximum primary benefit is raised from \$85 to \$98.50 for retired persons and to \$108.50 for future beneficiaries; and the maximum family benefit is raised from \$168.75 to \$190. The only benefit changes in the Curtis bill are in minimum payments, with the minimum

primary benefit being \$45 instead of \$30 as in the Reed bill.

### **Curtis Bill Would End Most Public Assistance Grants**

The Curtis bill differs materially from the Reed bill in that it would provide minimum benefits to the aged and orphans who are not presently covered by virtue of wage credits. This would place on the OASI benefit rolls an estimated 5,300,000 aged persons, 750,000 orphan children and 150,000 mothers of dependent children. At the same time, however, the present programs of Federal grants to the States for old-age assistance and aid to dependent children would be terminated.

These two grant programs were originally made a part of the Social Security Act to serve as temporary relief measures which were expected to decline in cost as the contributory OASI program matured. Instead of declining in importance they have continued to grow in competition with OASI as a source of benefits for old people and dependent children. The Federal share of the cost of these two programs in the current fiscal year will be about \$1.2 billion and the State and local share will be another billion dollars. Two other public assistance grant programs, aid to the blind and aid to the permanently and totally disabled, will cost the Federal Government about \$100 million. Analysis of the grant programs and their serious defects warrants a separate report and consequently cannot be made in these pages.

### **Costs Under Both Bills Would Go Up**

In estimating future revenues and benefit payments under OASI, actuaries of the Social Security Administration make computations on the basis of high and low cost assumptions and intermediate cost assumptions which are the mid-points between the high and low cost figures. Using the intermediate cost figures, the benefit costs of the Reed bill and present law compare as follows:

	<b>Present Law</b>	<b>Reed Bill</b>
1955	\$ 4.1 billion	\$ 4.7 billion
1960	5.7 "	7.2 "
1970	8.2 "	10.9 "
1980	10.8 "	14.8 "
1990	13.1 "	17.9 "
2000	14.3 "	19.3 "

To some extent the increased costs of the Reed bill over present law would be financed by the extension of coverage and by raising the taxable annual wage base from the present maximum of \$3600 to \$4200. Nevertheless, it is expected that benefits will exceed tax contributions by 1980 or earlier even with the acceleration in the rate of tax to 3½ per cent each on employer and employee by 1970. In comparison, the Curtis bill retains the \$3600 wage base and the rate schedule under present law.

Although it does not increase benefits generally, as does the Reed bill, the initial cost of the Curtis bill would be greater because of the provision which blankets in for minimum OASI benefits the aged and orphans not presently covered. The first year cost of this provision to the OASI Trust Fund would be about \$3 billion (\$2,700 million for the aged and \$310 million for orphans) but it would decline annually as the aged died and coverage for contributions became almost universal. Furthermore, the general fund of the Treasury would be relieved of the \$1.2 billion annual expense for the grant programs which would be eliminated.

### **Congress Should Rebuild Not Inflate the Present System**

The facts developed last year by the Curtis subcommittee clearly show the many weaknesses of the present dual Federal system of providing financial protection to the aged and to dependent children. The Administration's proposals for improving OASI would eliminate eventually many of the inequities stemming from inadequate coverage. On the other hand, they would increase through liberalized benefits the heavy burden of obligations we have already willed to the next generation. And the Administration's public assistance recommendations (H. R. 7200) do little to hasten the day when OASI will be the only Federal program for the aged and orphans.

Representative Curtis' bill offers solutions to many of the weaknesses in the present system. If the Congress will examine the facts developed by his subcommittee, it may concur with his proposals or possibly come up with better ones. But it will not solve the problems merely by expanding and liberalizing what is already faulty.

In deciding whether to rebuild or only to in-



flate the present system, Congress might well keep these three points in mind:

(1) The Congress should not forget that the real purpose of social security is to provide a basic floor of protection from want. The program has never been intended to replace personal savings, insurance or private pension plans. Accordingly, benefits should not be raised to a point which would reduce the incentive for people to provide for their own security. Under our private enterprise system that incentive is vital to the moral and economic strength of the nation.

(2) The Congress should keep in mind the desirability of a single Federal social purpose program for the aged and orphans instead of the present dual program. The Curtis bill shows

one way of accomplishing this practically and at an early date.

(3) The Congress should officially recognize the plain fact that the present contributory program is not insurance and should not be so considered. And instead of perpetuating the illusion of insurance, Congress might as well recognize the inevitable and make statutory the principle of pay-as-you-go. The late Senator Robert A. Taft took note of this in debate on amendments to the Social Security Act in 1950. He said,

"In the long run we have to recognize that the only way to pay those sums (benefits) is for the people who are working (at a given time) to pay the benefits for the people who are not working. There is no other way to do it."

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#### POST OFFICE URGES MORE CAREFUL BLOOD PACKAGING

An assistant postmaster in Chicago phoned my office recently and complained that many doctors are mailing blood specimens in glass vials placed in metal screw-topped cardboard tubes to private and governmental laboratories and, because of carelessness in screwing the tops on securely, the vials slip from the tubes, are broken, and the blood stains other mail. He pointed out one important fact from the doctor's viewpoint; if the postal employee re-inserts the vials in the tubes, who knows whose blood goes into whose tube?

The assistant postmaster said the same trouble exists in other postal centers and urged us to publicize what he called "this dangerous nuisance."

He urged doctors to place an adhesive strip (not scotch tape) across the metal top and down the sides of the container. This, he said, will prevent the insecurely screwed tops from coming off.

—George F. Lull, M.D.



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## STANDARDIZATION OF INSURANCE CLAIM FORMS

EVERYONE CONCERNED with the completion and processing of medical insurance claim forms—doctors and insurance people alike—agree that simplification and standardization of forms would be a tremendous help to all.

The Health Insurance Council, which represents a large portion of the industry, recently made a progress report on their work toward this end.

More than 100 million persons in the United States are protected by one or more kinds of health insurance. Claims in the accident and health field amount to more than 10 million per year. Almost \$300,000,000 is paid annually. Even these tremendous figures are still on the increase, and it is obvious that everything pos-

sible should be done to reduce the paper work to a safe minimum.

Already a uniform claim form for group hospital insurance is in general use, and more than 85 percent of the life insurance companies have adopted uniform forms. At present work is proceeding on the forms for other types of coverage.

Advice from hospital and medical associations is sought. All forms finally adopted will be brief, and simply and clearly worded, and will be adequate from the standpoint of the insurance carriers.

The adoption of a system of standardized forms, industry-wide and nation-wide, will be of tremendous help to the busy physician, and will indirectly benefit the patient who is the ultimate beneficiary of the splendid system of health insurance now being built in the United States.

## INDIANA COOPERATES FULLY IN POLIO RESEARCH

**F**IELD TRIAL of the Salk poliomyelitis vaccine was well on its way in Indiana when the third series of injections was finished early in June. Eight counties, selected on the basis of previous incidence of infantile paralysis, are taking part in the national research project to determine the effectiveness of the vaccine.

Preliminary investigation has given evidence that the Salk type vaccine is both potent and essentially harmless. The present nation-wide test will demonstrate its clinical capabilities in either preventing the disease or in ameliorating its effects.

The vaccine has been administered in three injections at three week intervals to all children in the eight counties who are in the second grade of school and whose parents have given written consent. Control of the results will be partially accomplished by determining the titer of antibodies in approximately two percent of the children in the first three grades at three different times—at the time of the first vaccination, two weeks after the third vaccination, and again at some time next fall.

Epidemiological studies will be made during the summer on all cases of clinical poliomyelitis which occur in children of the first three grades in the eight test counties. This will include all vaccinated children of the second grade, whose experience with the disease will be compared with the unvaccinated children of the second grade and with those of the first and third grades, none of whom has received the vaccine.

In addition to following all cases of polio in these three grades, special studies will be made of cases which develop in the families of these children.

Over 15,000 second grade children have been vaccinated in Indiana. This is about 75 percent of the total class. This percentage of participation will probably exceed the national average. A small number of those who received the first injection were prevented from receiving the second dose because of intercurrent illness. Many of these will attend make-up clinics, so that the total number of participants will remain high. About 200,000 second graders in the entire country have received the vaccine.

The success of the undertaking in Indiana so far is due in a large measure to the public spirited and generous association by doctors, nurses, pharmacists and teachers. Members of these groups in the counties of Allen, Delaware, Elkhart, Howard, Madison, St. Joseph, Tippecanoe and Vanderburgh are to be congratulated on their having organized the project in an extremely efficient manner in a short space of time, and for having contributed their services without remuneration.

The medical profession's handling of the entire problem has engendered public confidence in the vaccine, and has produced a high degree of participation on the part of those eligible to receive the vaccination. The administration of better than 45,000 injections of the vaccine was accomplished without any serious reactions and without any untoward incidents.

## MEDICAL FORUMS

The first open Medical Forum ever held in Kanawha county drew an audience in excess of 2,000 persons at the Municipal Auditorium in Charleston on Wednesday, March 24. The forum was sponsored by the Kanawha Welfare Council, Kanawha Medical Society and Auxiliary, and the Charleston Gazette.

Mayor John T. Copenhaver, of Charleston, delivered the address of welcome, and Dr. William L. Cooke, served as moderator.

The principal address was delivered by Dr.

Paul H. Revercomb, his subject being "Joint Pains, Rheumatism and Arthritis." The other members of the panel were Drs. Howard A. Swart, H. M. Hills, J. Paul Aliff, and Richard N. O'Dell, all of Charleston.

Questions which were mailed to the Charleston Gazette were considered and answered by the members of the panel.

The following editorial written by Frank A. Knight, managing editor of the Gazette, headed "Cheers for the MD's," appeared in his paper on

Sunday, March 28, and his comments will be interesting not only to the medical profession and to those who attended the forum but to all persons interested in the subjects discussed:

The doctors, bless them, have not always agreed with this newspaper nor, for that matter, has The Gazette always sided in with the MD's. But on Wednesday night last we got along famously, and so did more than 2,000 persons who attended the first "You and Your Health" medical forum at the municipal auditorium. The meeting, and three more to follow, are sponsored by both groups in addition to the Kanawha Welfare Council.

Here, as we see it, is public service at its pinnacle. In the course of a year The Gazette sponsors many events ranging from football games to sewing contests and including university scholarships, but nothing more important than the people's health.

We approached the first forum with trepidation. Would the public, although admission was free, respond to our joint invitations to learn more about itself? Would the panel of physicians, unaccustomed to appearances before large audiences, perform in a fashion that would not only give satisfactory replies to the varied questions mailed in by our readers but also display that necessary fifth sense of showmanship?

Only time would tell, and now that the ice has been successfully cracked we realize more fully than ever that we share many mutual problems with the honored

profession of medicine and surgery along with the welfare agencies. By working together, as we have, we should be able to consolidate our efforts into more benefits for the people.

This doesn't mean that the future doesn't hold differences of opinion and procedure, but it does result in a better understanding of the other's approach toward the same goals. We might add what we have said many times, to wit:

Go where you wish and be treated as you may, but don't ever fool yourself that Charleston and the Kanawha Valley—as a whole—do not have more than their share of the country's best doctors.

There is no doubt that the medical forum idea which is spreading over the country has taken firm roots in Charleston, and the pattern for the meeting follows closely forums already held in Morgantown and other West Virginia cities, and in some of the larger cities over the country.

The second of the series of medical forums in Kanawha County is being held (April 21) at the Municipal Auditorium in Charleston as this issue of the Journal goes to press. The subject being discussed is "Heart Trouble and High Blood Pressure."

West Virginia Medical Journal

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## ADVANTAGES OF THE PRECEPTOR PLAN DISCUSSED BY TWO INDIANA DOCTORS

Lester D. Bibler, M.D., Indianapolis, chairman of the Sub-Committee on Preceptorships of Indiana State Medical Association, requested these opinions from Dr. Harry E. Voyles, New Albany, who has been in practice 32 years, and from Dr. C. F. Voyles, Indianapolis, who has been in the active practice of medicine for 56 years.

*Harry E. Voyles, a member of the Preceptorship committee, writes:*

**T**HE MARCH OF MODERN MEDICINE is leaving in its wake a two-fold problem affecting medical students, medical educators, and medicine's relationship with the public it serves.

First, the rapid progress of research has resulted in such a tremendous increase in the body of specific knowledge that today's graduate honestly feels he can not practice good medicine away from the large centers which offer the intricate laboratory facilities, and diagnostic and therapeutic machinery of modern medicine he has learned to depend upon.

For this reason he shies away from general practice in small towns or rural areas, thus furthering the imbalance of the nation's distribution of medical service.

Second, it is widely recognized that the exceedingly high quality of scientific education currently offered students unfortunately fails to acquaint them adequately with the Art of medicine; more today than ever before a part of medicine as important in healing as antibiotics and x-rays.

There is, however, an answer which may work towards solving both these problems . . . the preceptor plan for medical students.

A program already adopted by more than 20 schools in several states,<sup>1</sup> the preceptor plan aims at bridging the gap between the science of medicine and the art of medicine by broadening the student's education to include a living "laboratory" period with a practicing physician, preferably in a small town or rural area.

While on his preceptorship the student lives

with or close by the physician preceptor. He is with the preceptor when he sees patients in the office or on day or night home calls, as well as hospital calls. He assists the physician in minor or major procedures, depending on his abilities. He is introduced to the public health and sociological problems which a general practitioner must often solve. He also meets many people from whom he can learn; the pharmacist, the dentist, the city fathers, the public health officer, the social service representatives. He attends civic club and county medical meetings with his preceptor and in this manner sees the practice of medicine in all its aspects at first hand.

It has been found that once the preceptor plan is under way, a high percentage of the students participating elect general practice. Also, statements from others indicate general approval of the plan even in cases where specialization is later decided upon.

Today's medical student is excellently prepared to participate in the preceptor plan. He has been carefully selected from a large group and well educated in all the basic sciences; he is, in short, better prepared to practice medicine than in any previous period. His aim is service; his ideals are high and he will go where he is needed. But he wants to give his patients his best, and he honestly believes he can not give his best away from the modern hospital with the facilities he has been trained to use.

The preceptor plan is a three dimensional refutation of the graduates' logic. By working with and living with the preceptor, he is in a position to learn for himself what a text could never show him: that the highest caliber of modern medicine not only can be, but is being practiced by general practitioners in non-metropolitan areas.

He also observes closely under ideal conditions the activities of the private physician<sup>2</sup> as he deals not only with good scientific medicine but with the business of his office and with the community in general.

And perhaps most important, he learns for the first time that without the general practitioner's personal relations in the treatment of his patients, the practice of medicine can become a Ford assembly line handling chassis instead of people.

It is this personalized concept of treatment that is part of the elusive term Art of medicine. Observation of this Art in practice is perhaps the greatest advantage of the preceptor plan. The term is difficult to describe but is part of the general practitioner's personality. It can be developed through experience providing the student couples a thorough basic training with a sincere love and interest in people themselves, as well as in their pathology.

If he is interested enough in them to know about their work, their hobbies, their friends, their worries, their weaknesses, their strengths, and has a demonstrative enthusiasm in his work, he will find he is developing a "contagious confidence" which is so necessary in practicing the Art of medicine.

The preceptee will find that this contagious confidence is medicine itself when dealing with fear. And he will discover that fear is a great part of genuine pathology as he observes that as much as 50% of his preceptor's practice consists of ills no x-ray will diagnose, no penicillin will cure. In order to deal with this end of practice he will see that the preceptor views his patients as total human beings complete with their economic, environmental, familial, and social facets. He will see that such a view is integral to the practice of the Art of medicine.

The student preceptee will also find his experience will better equip him for his later internship; for having been treated as a human and given responsibilities, he will have gained confidence in himself while learning from first hand observation that the general public has great faith and confidence in the general practitioner.

The preceptor plan is also an excellent opportunity to give the student a chance to learn something about himself. It has proven invaluable in helping students choose the direction

of their medical careers; some preceptees see at first hand that general practice is not for them; others, who thought they would not choose G.P., return from preceptorships G.P. enthusiasts.

An additional advantage to the student is his chance to see the business side of medicine. The medical student is poorly trained in business because he has been removed from the business world longer than the average man. But as a doctor he must do business in a business way, for often his patients are business men who will judge his medical ability to some extent on his conduct of his medical business. The preceptorship gives him an opportunity to see the preceptor manage his office with the best help available, training good personnel to do what he does not have time to do. He will see that his medical staff includes a good bookkeeper to keep records, watch accounts, file charts, pay bills and help in the general management of the office.

These observations will help the student meet the economics of medicine directly. Textbooks usually are no help for a student's questions about fees, collections, charity work, taxes, overhead, employees, and relationships with other local doctors. The preceptor plan adds this important learning to the student's program.

The preceptor gains, too, from the plan. The doctor on Mark Hopkins' end of this classical learning log, will find that although the student takes time, working with him will help revise for himself his early medical dreams . . . will inspire him to do better work. The program will also bring to his attention the latest ideas and concepts of diagnosis and treatment from the medical schools. He will face re-evaluation of his methodology. And he will have the opportunity to give back to his profession many of the facts and methods he has learned through experience to be of value . . . facts and methods which he will never write about or talk about, and which without the preceptor plan would die with him.

The general public as well as medicine in general profits from the plan too, for whether the student finally becomes G.P. or specialist, he is probably a better doctor for his preceptorship and being a better doctor will add to the advance of medical care.

The preceptor plan is not new. In its basic

conception it is as old as the tutorial method of Hippocrates. It was in use in medical training until the age of modern medicine. Re-instated in the late '20s, it has gradually taken hold again. Only experience will determine its ultimate effectiveness and it must be well supervised, of course. Currently the plan is varied in different areas, but generally is considered to be most valuable to a senior student. In some places the time involved is five and one-half weeks; in others three months.

### Summary

In summary, the preceptor plan for medical students gives them the opportunity to learn first hand that good scientific medicine can be practiced away from large medical centers; gives them an inside view of the practice of the elusive Art of medicine; shows them something also of the business of medicine. Because of these advantages it promises to help perpetuate the Art of medicine and may help alleviate the shortage of doctors in non-metropolitan areas by letting the student see for himself the advantages and satisfactions of such practice.

1. J.A.M.A., September 13, 1953. Page 120.
2. J.A.M.A., January 5, 1952. Page 60.

Dr. C. F. Voyles, says briefly:

Since medical practice is both a science and an art it seems evident that the basic science is learned mainly in college and that the art of

practice is not acquired by the student looking on at charity clinics. Something more is needed and the preceptorship seems to be the best the profession has to offer.

My preceptorship was served at an earlier period when medical training had less to offer, however I regard that training as a valuable part of my medical education.

In that day some graduates of my age group were impressed with taking refresher courses in postgraduate schools. We sat on benches and for the most part watched our professors make examinations, do major operations and some lecturing—a poor substitute for a high class preceptorship.

### Conclusion

Doctor Bibler in a paper prepared for another publication recently disclosed that a survey taken at the Indiana University School of Medicine where the preceptorship program will go into effect in the fall shows that 75 percent of those questioned, all students of the junior and senior classes, were interested in preceptorships; 85 percent preferred rural areas under 10,000 population, and 75 percent preferred a six weeks' preceptorship.

Fifty Indiana doctors have volunteered to participate in the preceptorship program and 15 medical students have indicated they wish to serve a preceptorship.

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### A.M.E.F. GRANTS "AWARDS OF MERIT"

Fifteen individuals and 17 organizations will receive the American Medical Education Foundation's "Award of Merit" for outstanding service to the Foundation during 1953. The citations are given for "outstanding contributions to the preservation and continuance of the high standards of medical education in the United States of America."

Dr. Herbert H. Inlow, Shelbyville, was listed among the recipients of the award in April.



## ISMA PAST PRESIDENT PAUL CRIMM GOES TO OHIO: BOEHNE HAS NEW DIRECTOR

**J**OSEPH E. MOODY, M.D., 39, assumed the directorship of Boehne Tuberculosis Hospital, Evansville, June 1. He went to Boehne from Leland Sanatorium, Ypsilanti, Michigan, where he had been medical director for a year. He was selected by the Boehne Hospital board of managers as medical director and superintendent on the recommendation of authorities in the field of tuberculosis treatment and chest surgery.

Two parallels exist in the lives of Doctor Moody and Doctor Paul D. Crimm, his predecessor at Boehne. Both have had tuberculosis; both have dedicated their professional lives to its eradication.

Doctor Moody received his medical degree in 1938 from the University of Louisville School of Medicine. He had attended Transylvania College, Lexington, Kentucky, previously. Internship and residency were served at Waverly Hills Sanatorium, Waverly Hills, Kentucky, in 1939 and 1940. Successively he was staff physician at Dunham Hospital, Cincinnati, Arkansas State Sanatorium, and Eastern Oklahoma State Sanatorium during the four years from 1940 to 1944. In 1944 he became assistant medical director at Benjamin Franklin Hospital, Columbus, Ohio, where he remained for five years. In 1949 he became medical director of the American Legion Hospital at Battle Creek, Michigan and from 1953 until June, 1954 he was medical director at Leland Sanatorium.

While in Columbus, Ohio, from 1944 to 1949 Doctor Moody was an instructor in medicine at Ohio State University Medical School.

He was licensed by examination to practice medicine in Kentucky and has been licensed by reciprocity in Ohio, Michigan and Indiana.

He is a member of Michigan State and Washenaw County Medical Societies, the American Trudeau Society, American College of Chest Physicians and the American Medical Association.



Dr. Moody

**“I**N ALL ABUNDANCE THERE IS LACK” was the thought behind the resignation of Paul D. Crimm, M.D., as director of Boehne Tuberculosis Hospital, Evansville, after 25 years of service there. He saw Boehne Camp—a place where consumptives went to die, a place where a pig sty was at the front gate and a cow barn was remodeled for the resident doctor’s home—become a modern 130-bed tuberculosis hospital. He saw Vanderburgh County’s death rate from tuberculosis spiral gradually downward from 80 per 100,000 to 13 per 100,000. He performed the first lobectomy in Indiana and was the first to use thoracoplasty in chest surgery. He had accomplished what he could—given what he could of his skill, and the challenge was gone.

In his own words, he told it this way after receiving the Rotary Club’s 1953 Civic Award on May 18:

“I expect Evansville still holds some chal-



Dr. Crimm

lenges for you fellows. But for an old medicine man in his declining years, its better to sit on a pumpkin and have it to yourself than to be crowded off a velvet cushion."

On July 1 Dr. Paul Crimm started a new career in Sidney, Ohio. He joined his younger brother, Dr. H. Eugene Crimm, in the general practice of surgery. They are occupying a spacious, remodeled quarters in the Ohio Building.

With him went a resolution adopted by Vanderburgh County Medical Society commending him to his new colleagues and to the community. The resolution said "During the 25 years of his life spent among us he received and merited numerous honors, not alone in the field of medicine, but abundantly for community service."

Tributes, frequently contained only in obituaries, were paid Dr. Crimm during his last month in Evansville. Rotary's Paul Crimm Day was attended by leaders from all professions and businesses. Evansville daily papers reported the award generously and editors of both papers recounted the many contributions Doctor Crimm made to the community during his quarter of a century there.

The editor of the Evansville Courier wrote: "The widespread approval with which this award (Rotary Civic Award for 1953) is being seconded in the community is Evansville's tribute to a doer, a leader, a good companion, and a man who thinks straight and says what he thinks. It is a deserved recognition of achievement and the long and constructive influence of a strong personality."

The Evansville Press editor concluded his lengthy editorial with this: "... In this respect it is men like Dr. Crimm who are the balance wheels of a community, for they temper quickly-caught enthusiasms with sober judgment.

"It would not be realistic to say that Dr. Crimm always has been right, or to say he retires from public life in Evansville May 25 with a heritage of friends unmixed with opponents.

"People who do things always develop some community resentments.

"But Dr. Crimm leaves Evansville with his personal imprint all over it. He leaves behind him a wholesome respect for his varied abilities, and gratitude for what he has done."

All of the biographical data repeated at the public affairs planned to honor Doctor Crimm was published when he was elected and served as president of the Indiana State Medical Association in 1952-53. His services as president of the Indiana Tuberculosis Association, as a Rotary governor, a Shrine potentate have all been enumerated.

Members of ISMA know of his prolific medical writing. Sixty-five scientific papers have been published throughout the United States. One was a report on research for which he personally read 86,600 chest x-ray films.

A story connected with that has not been told previously.

Doctor Crimm was paid to read those x-rays, taken by the county mobile unit he helped acquire in 1934. But for 10 years he refused to accept any of the money for himself. He used it to establish a medical research fund; he established a student technician loan fund of \$2,500; he gave \$1,475 to equip the x-ray machine at Boehne Hospital; he made other gifts from that fund which will remain to benefit the community.

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Rosters of Indiana State Medical Association officers, District and County Medical Society officers and other organizational information are listed on Pages 730-732.

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(June 1, 1954)

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## APPROVED HOSPITALS IN INDIANA\*

June 1, 1954

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Adams County Memorial Hospital.  
804 Mercer Ave., Decatur.

**ALLEN COUNTY**

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Parkview Memorial Hospital, Inc.  
State and Randalia Dr., Fort Wayne.  
O. T. Kidder, M.D., Adm. & Med. Dir.  
Irene Byron Sanatorium.  
R. R. 13, Lima Road North, Fort Wayne  
Mr. E. C. Moeller, Adm.  
The Lutheran Hospital of Fort Wayne.  
3024 Fairfield Ave., Fort Wayne.  
Sister M. Augusta, R.N., Adm.  
St. Joseph Hospital.  
730 W. Berry St., Fort Wayne.

**BARTHOLOMEW COUNTY**

Miss Olive M. Murphy, R.N., Adm.  
Bartholomew County Hospital.  
East 17th St., Columbus.

**BLACKFORD COUNTY**

Miss Mabel Brown, Adm.  
Blackford County Hospital.  
503 E. Van Cleve St., Hartford City.

**BOONE COUNTY**

Mrs. Lottie M. Dodson, Adm.  
Witham Memorial Hospital.  
1124 N. Lebanon St., Lebanon.

**CASS COUNTY**

William W. Turner, Adm.  
Memorial Hospital.  
1101-1115 Michigan Ave., Logansport.  
Sister M. Joachime, Adm.  
St. Joseph Hospital.  
26th and North Sts., Logansport.

**CLARK COUNTY**

Mr. William McAlexander, Adm.  
Clark County Memorial Hospital.  
210 Sparks Ave., Jeffersonville.

**CLAY COUNTY**

Miss Helen L. Broughton, R.N., Adm.  
Clay County Hospital.  
1206 E. National Ave., Brazil.

**CLINTON COUNTY**

Miss Maude M. Woodard, R.N., Adm.  
Clinton County Hospital.  
1300 S. Jackson St., Frankfort.

**DAVISS COUNTY**

Mrs. Olive B. DeHart, R.N., Adm.  
Daviess County Hospital.  
1307 Bedford Road, Washington.

**DECATUR COUNTY**

Miss Juliana K. Huser, R.N., Adm.  
Decatur County Memorial Hospital.  
720 N. Lincoln St., Greensburg.

**DEKALB COUNTY**

Bonnell M. Souder, M.D., Adm.  
Dr. Bonnell M. Souder Hospital.  
206 W. 7th St., Auburn.  
Sister M. Daniela, Adm.  
Sacred Heart Hospital.  
220 S. Ijams St., Garrett.  
Jesse A. Sanders, M.D., Adm.  
Sanders General Hospital.  
1007 S. Main St., Auburn.

**DELAWARE COUNTY**

Mr. Walter G. Ebert, Adm.  
Ball Memorial Hospital.  
2401 University Ave., Muncie.

**DUBOIS COUNTY**

Sister Mary James, Adm.  
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530 4th St., Huntingburg.  
Mother M. Catherine, Adm.  
Memorial Hospital of Dubois County.  
800 West 9th St., Jasper.

**ELKHART COUNTY**

Emery K. Zimmerman, Adm.  
Elkhart General Hospital.  
1100 South Boulevard, Elkhart.  
Mrs. Lois Sinner Ulery, Adm.  
Goshen Hospital.  
112-116 N. 5th St., Goshen.

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1941 Virginia Ave., Connersville.

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Memorial Hospital of Floyd County  
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Sister M. Joan, R.N., Adm.  
St. Edward Hospital.  
701 E. Spring St., New Albany.  
J. V. Pace, M.D., Adm.  
Silvercrest.  
(Southern Indiana Tuberculosis Hospital)  
New Albany.

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\* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

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Wabash and Euclid, Marion.

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Hancock County Memorial Hospital.  
800 North Street, Greenfield.

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King's Daughters' Hospital.  
112 Presbyterian Ave., Madison.

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R.R. 1, Franklin.

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410 S. 7th St., Vincennes.  
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North 2nd St. Road, Vincennes.

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McDonald Hospital.  
Center and Argonne Road, Warsaw.  
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**LAGRANGE COUNTY**

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LaGrange.

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**Wabash Employees Hospital Association.**  
North Broadway, Peru.

**MONROE COUNTY**

Miss Anna G. Nelson, Adm.  
**Bloomington Hospital.**  
640 S. Rogers St., Bloomington.

**MONTGOMERY COUNTY**

Mr. Ralph M. Haas, Adm.  
**Montgomery County Culver Union Hospital.**  
308 Binford St., Crawfordsville.

**MORGAN COUNTY**

K. E. Comer, M.D., Adm.  
**Comer Sanitarium.**  
130 N. Indiana St., Mooresville.  
Mrs. Crystal L. LaBonte, R.N., Adm.  
**Morgan County Memorial Hospital.**  
190 S. Main St., Martinsville.

**NOBLE COUNTY**

Harold A. Luckey, M.D., Adm.  
**Luckey Hospital.**  
Wolflake.  
Sister M. Joseph, Adm.  
**Kneipp Springs Sanatorium.**  
Rome City.

Miss Bertha E. Dean, R.N., Adm.  
**McCray Memorial Hospital.**  
Hospital Drive, Kendallville.

**ORANGE COUNTY**

Ivan A. Clark, M.D., Adm.  
**Paoli Hospital Foundation, Inc.**  
308 E. Main St., Paoli.

**PARKE COUNTY**

Robert A. Staff, M.D., Adm.  
**Indiana State Sanatorium.**  
R.R. 1, Rockville.

**PERRY COUNTY**

Robert G. Gilbert, M.D., Adm.  
**Perry County Memorial Hospital.**  
Star Route, Tell City, Ind.

**PORTER COUNTY**

Mr. R. Edwin Hawkins, Jr., Adm.  
**Porter Memorial Hospital.**  
814 LaPorte Ave., Valparaiso.

**PULASKI COUNTY**

Thomas E. Carneal, M.D., Adm.\*  
**Carneal's Private Hospital.**  
111 N. Monticello St., Winamac.

**PUTNAM COUNTY**

Miss Clarice L. Bemis, R.N., Acting Adm.  
**Putnam County Hospital.**  
322 Greenwood Ave., Greencastle.

**RANDOLPH COUNTY**

Mr. Vernon W. Hyer, Adm.  
**Randolph County Hospital.**  
Oak Street, Winchester.  
Miss Kathryn E. Larrance, Adm.  
**Union City Hospital.**  
702 W. Division St., Union City.

**RIPLEY COUNTY**

Sister M. Gerard, R.N., Adm.  
**Margaret Mary Hospital.**  
Rosemont Division, Batesville.  
Henry W. Conrad, M.D., Adm.  
**The Whitlatch Clinic and Hospital, Inc.**  
Milan.

**RUSH COUNTY**

Miss Ida Mae Mouchette, R.N., Dir. of Nurses  
**Rush Memorial Hospital.**  
Main at 13th St., Rushville.

\* License pending until certain noncompliances are met.



**SCOTT COUNTY**

Floyd S. Napper, M.D., Adm.  
**Napper Hospital.**  
 69 Wardell St., Scottsburg.

**SHELBY COUNTY**

Mrs. Frances Pruitt, R.N., Adm.  
**William S. Major Hospital.**  
 150 W. Washington St., Shelbyville.

**ST. JOSEPH COUNTY**

E. W. Custer, M.D., Adm.  
**Healthwin Hospital.**  
 1111 West Darden Road, South Bend.  
 John C. Van Metre, Adm.  
**Northern Indiana Children's Hospital.**  
 1234 N. Notre Dame Ave., South Bend.  
 Mr. Richard W. Trenkner, Adm.  
**Memorial Hospital of South Bend.**  
 604 N. Main St., South Bend.  
 Sister M. Reginalda, R.N., Adm.  
**St. Joseph Hospital.**  
 1215 W. 4th St., Mishawaka.  
 Sister Miriam Dolores, R.N., Adm.  
**St. Joseph's Hospital.**  
 401 N. Notre Dame Ave., South Bend.  
 A. F. Kull, D.O., Adm.  
**South Bend Osteopathic Hospital.**  
 118 S. William St., South Bend.

**STARKE COUNTY**

Miss Marie N. Knapp, R.N., Adm.  
**Starke Memorial Hospital.**  
 Culver Road, Knox.

**STEUBEN COUNTY**

Mrs. Daisy McCallister, R.N., Adm.  
**Cameron Hospitals, Inc.**  
 416 E. Maumee, Angola.  
 Miss Bessie Cottrell, R.N., Adm.  
**Elmhurst Hospital, Inc.**  
 609 W. Maumee, Angola.

**SULLIVAN COUNTY**

Miss Mabel A. Cook, R.N., Adm.  
**Mary Sherman Hospital.**  
 320 N. Section St., Sullivan.

**TIPPECANOE COUNTY**

Mr. T. E. Berg, Adm.  
**Lafayette Home Hospital.**  
 2400 E. South St., Lafayette.  
 Sister M. Amelia, R.N., Adm.  
**St. Elizabeth Hospital.**  
 1021 N. 14th St., Lafayette.  
 J. W. Strayer, M.D., Adm.  
**William Ross Sanatorium.**  
 R.R. 6, State Road No. 52, Lafayette.

**TIPTON COUNTY**

Mr. Harry L. Gable, Adm.  
**Tipton County Memorial Hospital.**  
 South Main Street, Tipton.

**VANDEBURGH COUNTY**

Joseph E. Moody, M.D., Adm.  
**Boehne Tuberculosis Hospital.**  
 Upper Mount Vernon Road, Zone 12, Evansville.

Albert G. Hahn, L.H.D., Adm.  
**Protestant Deaconess Hospital.**  
 600-700 Mary St., Evansville.  
 Sister Justina, Adm.  
**St. Mary's Hospital, Inc.**  
 713 First Ave., Evansville.  
 Mr. Crayton E. Mann, Adm.  
**Welborn Memorial Baptist Hospital, Inc.**  
 412 S.E. 4th St., Evansville.

**VERMILLION COUNTY**

Miss Hannah Rosser, R.N., Adm.  
**Vermillion County Hospital.**  
 800 S. Main St., Clinton.

**VIGO COUNTY**

Mrs. Arlie L. Dwyer, R.N., Adm.  
**Florence Crittendon Home and Hospital.**  
 1923 Poplar St., Terre Haute.  
 D. A. Hoover, MD., Adm.  
**Hoover Sanatorium.**  
 2144 8th Ave., Terre Haute.  
 Sister M. Ludolpha, Adm.  
**St. Anthony Hospital.**  
 1021 S. 6th St., Terre Haute.  
 I. Herman Sloss, M.D., Adm.  
**Sloss Hospital.**  
 1029 S. 7th St., Terre Haute.  
 Ellen E. Church, R.N., Adm.  
**Union Hospital, Inc.**  
 7th St. at 8th Ave., Terre Haute.

**WABASH COUNTY**

Mrs. E. A. Ford, Actg. Adm.  
**Wabash County Hospital.**  
 670 N. East St., Wabash.

**WARREN COUNTY**

Mrs. Nellie O. Rudolph, Adm.  
**The Community Hospital.**  
 412 N. Monroe St., Williamsport.

**WASHINGTON COUNTY**

Harry M. Voyles, Adm.  
**Washington County Memorial Hospital.**  
 Shelby Street, Salem.

**WAYNE COUNTY**

Mr. Frank G. Sheffler, Adm.  
**Reid Memorial Hospital.**  
 Spring Grove, Richmond.  
 R. J. Hanna, M.D., Adm.  
**Smith Esteb Memorial Hospital.**  
 R. R. No. 4, Liberty Pike, Richmond.

**WELLS COUNTY**

Mrs. Eileen Stipp, Adm.  
**Clinic Hospital.**  
 309 S. Main St., Bluffton.  
 Mrs. Clara Steiner, Adm.  
**Wells County Hospital.**  
 1116 S. Main St., Bluffton.

**WHITLEY COUNTY**

Mr. Carl F. Arnston, Adm.  
**Memorial Hospital.**  
 215 E. Van Buren St., Columbia City.  
 Mr. Stanley S. Mullendore, Adm.  
**Whitley County Memorial Hospital.**  
 353 N. Oak St., Columbia City.

# LICENSED NURSING HOMES IN INDIANA

(As of June 1, 1954)

## ADAMS COUNTY

**Berne Nursing Home**  
906 W. Main St., Berne  
Miss Pauline Hostetler  
**Smith Recovery Home**  
Cor. Butcher and High Sts.,  
Geneva  
Mrs. Fanny B. Smith

## ALLEN COUNTY

**Colonial Nursing Home**  
802 W. Berry St., Fort Wayne  
Abe Latker  
**Crater Nursing Home**  
1407 E. Wayne St., Fort Wayne  
Mrs. Pearl Crater  
"Crow's Haven"  
2440 Bowser St., Fort Wayne  
Mrs. Meta Crow  
**Grace Convalescent Home**  
1529 California Ave., Fort  
Wayne  
Mrs. Jessie G. Richer  
**Lawton Nursing Home**  
1649 Spy Run Ave., Fort Wayne  
Mr. Walter C. Buuck  
**Leslee Home**  
906 Lake Ave., Fort Wayne  
Mrs. Leona Hollman  
**Munson Home**  
336 Madison St., Fort Wayne  
Mrs. Mabel Munson  
**Slay Nursing Home**  
1211 S. Lafayette St., Fort  
Wayne  
Mrs. Eva B. Slay  
**Twin Maples Sanitarium**  
734 W. Washington Blvd., Fort  
Wayne  
Mrs. Maude M. Cole, R.N.  
**West Berry Street Rest Home**  
903 W. Berry St., Fort Wayne  
Herbert E. Atkinson, Sr.

## BARTHOLOMEW COUNTY

**Boilanger Nursing Home**  
213 Fourth St., Columbus  
Mrs. Everly Boilanger  
**Brown Nursing Home**  
318 Smith St., Columbus  
Mr. Ithamer Brown  
**Redman's Sanitarium**  
R. R. 4, Columbus  
Frank A. and Nellie D. Redman  
**Shanklin Nursing Home**  
705 Sycamore St., Columbus  
Mrs. Mildred Shanklin

## BENTON COUNTY

**Neal Nursing Home**  
3rd and Maple Sts., Earl Park  
Mrs. Genevieve L. Neal  
**Ellsworth Nursing Home**  
Smith St., Oxford  
Mrs. Bertha Ellsworth

## BLACKFORD COUNTY

**Waldo House**  
511 W. Washington St.,  
Hartford City  
Mrs. Martha Waldo  
**Jackson Convalescent Home**  
423 S. Main St., Montpelier  
Rolland W. Jackson

## BOONE COUNTY

**English Nursing Home**  
304 W. Washington St., Lebanon  
Mrs. Bessie M. English  
**Trammel Nursing Home**  
415 N. Clark St., Lebanon  
Mrs. Sarah S. Trammel  
**Davis Nursing Home**  
310 W. Main St., Thorntown  
Mrs. Ruth Davis

**Fultz Nursing Home**  
40 N. Third St., Zionsville  
Mrs. Bertha Fultz

## CARROLL COUNTY

**Deer Creek Nursing Home**  
R. R. 1, Camden  
Miss Mabel E. Bechdolt  
**Good Will Nursing Home**  
Corner Main and Monroe Sts.,  
Camden  
Mrs. Bertha Neibel  
**Cornell Nursing Home**  
R. R. 1, Cutler  
Mrs. Victoria Cornell  
**Porter Nursing Home**  
616 E. Monroe St., Delphi  
Mrs. Alsie J. Porter  
**The Arzula Flora Nursing Home**  
312 W. Main St., Flora  
Miss Ida Arzula Flora  
**Mamie Kennedy Nursing Home**  
404 S. Center St., Flora  
Mrs. Mamie Kennedy

## CASS COUNTY

**Effie Bell Nursing Home**  
R. R. 2, W. Jackson, Galveston  
Mrs. Effie Bell

**Galveston Nursing Home**  
Washington & Sycamore Sts.,  
Galveston  
Estie and Ednabelle Bell  
**Huffman Nursing Home**  
2533 E. Broadway, Logansport  
Mrs. Honour Ruth Huffman  
**Justice Nursing Home**  
227 Cliff Dr., Logansport  
Mr. and Mrs. Martin Justice  
**Rest Haven Nursing Home**  
731 North St., Logansport  
Miss Olive S. Jones  
**Rose Lawn Home**  
3026 E. Broadway, Logansport  
Miss Marie Wilsie Thomas  
**Webster Home**  
806 North St., Logansport  
Mrs. Nora B. Webster  
**Bird's Home**  
R. R. 2, Royal Center  
Mrs. Irene Bird  
**Flo Dodt Nursing Home**  
Royal Center  
Mrs. Flo Dodt

## CLARK COUNTY

**Griggs Nursing Home**  
208 W. Riverside Dr., Jefferson-  
ville  
Mrs. Mary C. Griggs  
**Keller Home**  
403 E. 7th St., Jeffersonville  
Mrs. Florence Keller  
**Maple Court Nursing Home**  
Maple Court, Box 29,  
Jeffersonville  
Mrs. Grace Stofel  
**Pleasant Nursing Home**  
1315 Spring St., Jeffersonville  
Leonard R. Pleasant  
**Twilight Nursing Home**  
210 E. Maple St., Jeffersonville  
Mrs. Delilah Jean Goodwin

## CLAY COUNTY

**Brazil Rest Home**  
508 E. National Ave., Brazil  
Mrs. James Garvin  
**Bridgewater Nursing Home**  
525 E. Mechanic St., Brazil  
Mrs. Goldie Bridgewater  
**Dove Dell Rest Home**  
36 N. Forest St., Clay City  
Mrs. Violet Langdon

**CLINTON COUNTY**

**Colfax Nursing Home**  
P.O. Box 826, Main St., Colfax  
Mrs. Francis M. Waggoner  
**Ashley Nursing & Convalescent Home**

R. R. 6, Frankfort  
Mrs. Jean Ashley Hladik  
**Harriet Ann Stoker Nursing Home**

R. R. 4, Frankfort  
Mrs. Harriet Ann Stoker

**DAVISS COUNTY**

**Baker's Nursing Home**  
819 Axtell Ave., Washington  
Mrs. Rose Ann Baker  
**Colvin's Nursing Home**  
1109 National Highway,  
Washington

Mrs. Laura Colvin  
**Meyers Nursing Home**  
215 W. Oak St., Washington  
Mrs. John Meyers  
**Meyers Nursing Home No. 2**  
209 W. Oak St., Washington  
Mrs. John Meyers

**DEARBORN COUNTY**

**Voshell Nursing Home**  
R. R. 1, Aurora  
Mrs. Nettie Voshell  
**Voelker Convalescent Home**  
Ridge Ave. and Catalpa St.,  
Lawrenceburg  
Mrs. Norine D. Voelker

**DECATUR COUNTY**

**The Black Nursing Home**  
619 W. Main St., Greensburg  
Mrs. Pearl Black  
**Davis Nursing Home**  
510 W. Washington St.,  
Greensburg  
Mrs. Edith Davis  
**Michigan Hill Nursing Home**  
320 S. Michigan Ave.,  
Greensburg

Mrs. Mary Clifton  
**The Ridout Nursing Home**  
410 S. Broadway, Greensburg  
Mrs. Lila Ridout  
**Jessup Nursing Home**  
Westport  
Mrs. Myrtle Jessup

**DEKALB COUNTY**

**Brouse Nursing Home**  
R. R. 2, Butler  
Mrs. Doris Mae Betz  
**Cox Nursing Home**  
R. R. 2, Butler  
Mrs. Mary Cox  
**Williams Convalescent Home**  
402 S. Broadway, Butler  
R. E. and Pauline Williams

**Williams Nursing Home #2**  
610 S. Broadway, Butler  
R. E. and Pauline Williams  
**Garrett Convalescent Home**  
611 S. Peters St., Garrett  
Mrs. Ursa Smith

**DELAWARE COUNTY**

**Arlis Clark Nursing Home**  
South St., Eaton  
Mrs. Arlis R. Clark  
**Freeman Nursing Home**  
1101 W. Powers St., Muncie  
Mrs. Mamie Freeman  
**Goodman Nursing Home**  
618 N. Elm St., Muncie  
Mrs. Edith Goodman  
**Hamilton's Nursing Home**  
1636 W. Tenth St., Muncie  
Mrs. Retta Hamilton  
**Morgan Convalescent Home**  
1408 E. Main St., Muncie  
Mrs. Rue Ann Morgan and  
Mrs. Lucy Mae Morgan  
**Nickols Convalescent Home**  
804 N. Jefferson St., Muncie  
Mrs. Margaret L. Nichols  
**Ring Home**  
R. R. 7, Muncie  
Mrs. Elizabeth Ring  
**Shady Haven Rest Home**  
R. R. 6, Muncie  
Mrs. Leila C. Wilcox  
**Sylvester Home for the Aged**  
R. R. 5, Burlington Dr., Muncie  
Mrs. Nellie V. Sylvester, R.N.  
**Williams Nursing Home**  
1525 S. Monroe St., Muncie  
Mrs. Rena Furnish  
**Woodland Home**  
917 E. Main St., Muncie  
Mrs. Hazel Wilson, R.N.  
**Karcher Home**  
Selma  
Mrs. Aida Karcher

**DUBOIS COUNTY**

**Mary Lees Nursing Home**  
701 Main St., Jasper  
Mrs. Mary Lee Schurz

**ELKHART COUNTY**

**Hope Convalescent Home**  
E. Vistula St., Bristol  
Mrs. Bernice Alverson  
**Florentine Convalescent Home**  
1005 S. Third St., Elkhart  
Mrs. Florentine Warskow  
**Milleman Convalescent Home**  
430 W. Marion St., Elkhart  
Mrs. Hazel Milleman  
**Cora Shaum Nursing Home**  
901 S. Second St., Elkhart  
Mrs. Cora Shaum

**Thorp Nursing Home**  
328 Franklin St., Elkhart  
Mrs. Ruth G. Thorp  
**The Austin Home**  
526 N. Sixth St., Goshen  
Mr. and Mrs. Fred S. Austin  
**Coil Convalescent Home**  
225 S. 5th St., Goshen  
Mrs. Wilma L. Coil  
**Hutchinson Nursing Home**  
402 S. Sixth St., Goshen  
Mrs. Irene Hutchinson  
**Lockerbie Nursing Home**  
302 E. Lincoln Ave., Goshen  
Mrs. Jane Ketring Barnes  
**Moore Nursing Home**  
401 S. Main St., Goshen  
Mr. and Mrs. Ralph Moore  
**Riley Convalescent Home**  
527 S. Main St., Goshen  
Albert and Eunice Riley  
**Rogers' Convalescent Home**  
807 N. Main St., Goshen  
Mrs. Goldie J. Rogers  
**Weaver Convalescent Home**  
R. R. 5, Goshen  
Mrs. Esther Weaver

**FAYETTE COUNTY**

**Clifton Nursing Home #3**  
224 S. Eastern Ave.,  
Connersville  
Mrs. Mary Clifton  
**Lincoln Manor**  
903 Lincoln Ave., Connersville  
Mr. Chester O'Neal

**FLOYD COUNTY**

**Rest Haven Nursing Home**  
909-11 E. Spring St.,  
New Albany  
Mrs. Sara Roy Seebert  
**Turley's Nursing Home**  
1003 E. Main St., New Albany  
Mrs. Anna Christine Turley

**FOUNTAIN COUNTY**

**Maplewood Nursing Home**  
R. R. 4, Veedersburg  
Mrs. Mable Butte and  
Mrs. Maxine Brown

**FRANKLIN COUNTY**

**The Resthaven Reifel Nursing Home**  
1015 Franklin St., Brookville  
Mrs. Elizabeth A. Reifel

**FULTON COUNTY**

**McFarland Nursing Home**  
719 Madison St., Rochester  
Mrs. Ralph McFarland  
**Rochester Nursing Home**  
1118 Main St., Rochester  
Gerald Eastburg



**GIBSON COUNTY**

Shady Grove Nursing Home  
Francisco  
Mrs. Ruth Morris  
Church Convalescent Home  
417 W. Broadway, Princeton  
Mrs. Edra E. Church  
Hitch Convalescent Home  
Patoka  
Mrs. Ethel M. Hitch  
Gorham's Private Rest Home  
807 S. Main St., Princeton  
Mrs. Amy Gorham Rees

**GRANT COUNTY**

Friendship Heights  
704 S. Main St., Fairmount  
Mrs. Margaret Meyer Lyons  
Smith's Nursing Home  
R. R. 2, Fairmount  
Arlene and Robert Smith  
The Roberts Nursing Home  
P.O. Box 102, Fowlerton  
Mrs. Ethel Roberts  
Frances' Nursing Home  
1827 S. Adams St., Marion  
Mrs. Frances Moore  
Lanter's Nursing Home  
1649 W. Second St., Marion  
Mrs. Anna Lanter  
Peterson Nursing Home  
1335 W. Nelson St., Marion  
Mrs. Ida Peterson  
Schove Nursing Home  
3904 S. Landess St., Marion  
Mrs. Thelma Schove  
Whiteman Nursing Home  
148 N. Branson St., Marion  
Mrs. B. E. Whiteman  
Campbell Nursing Home  
Box 53, Van Buren  
Mrs. Bertha O. Campbell

**HAMILTON COUNTY**

Arcadia Rest Home  
S. School St., P.O. Box 28,  
Arcadia  
Mrs. Florence Sigler  
Moore's Nursing Home  
South St., Arcadia  
Mrs. Anna Moore  
Sunderman Nursing Home  
Cass and Harrison Sts., Cicero  
Mr. and Mrs. B. H. Sunderman  
The Hamilton Home  
R. R. 5, Noblesville  
Mrs. Mary E. McKinley

**HANCOCK COUNTY**

Wood's Nursing Home  
14 N. Wood St., Greenfield  
Mrs. Hazel E. Wood  
Pleasant Acres  
R. R. 12, Box 320, Indianapolis  
Corner 56th & McCordsville Rd.  
Mr. Frederick M. Burns

**HARRISON COUNTY**

Old Capitol Rest Home  
408 N. Capitol Ave., Corydon  
Mrs. Hazel M. Brengman

**HENDRICKS COUNTY**

Milhon Nursing Home  
Clayton  
Mrs. Malissie E. Milhon  
Plainfield Nursing Home  
404 N. Vine St., Plainfield  
Miss Lois B. Thompson  
Perkins Nursing Home  
64 N. High St., Danville  
Mrs. Pearl Perkins

**HENRY COUNTY**

"The Boxwoods"  
115 N. 10th St., New Castle  
Mrs. Margaret Harris  
Homestead Nursing Home  
Spiceland  
Mr. and Mrs. William Whitacre  
Castle Nursing Home  
1122 S. 14th St., New Castle  
Mrs. M. Conner  
Rest Haven  
420 S. Main St., New Castle  
Mrs. Rebecca L. John

**HOWARD COUNTY**

Colonial Haven Nursing Home  
613 E. Superior St., Kokomo  
Mrs. Mae Kennedy  
Randle's Nursing Home  
630 S. Union St., Kokomo  
Mrs. Fern Randle  
Sunnyview Convalescent Home  
510 N. Market St., Kokomo  
Mrs. Mary Hess  
Twilite Nursing Home  
612 N. Webster St., Kokomo  
Mrs. Daisy Coy

**HUNTINGTON COUNTY**

Davis Nursing Home  
207 Frederick St., Huntington  
Mrs. Annette Davis  
DeKoning Convalescent Home  
R. R. 8, Huntington  
Mrs. Ann Cecilia DeKoning  
Jefferson Sanitarium  
414 S. Jefferson St., Huntington  
Herbert Earl Atkinson, Sr.  
Moore Home  
425 Hasty St., Huntington  
Mrs. Maud Moore  
Oak Park Sanitarium  
743 N. Main St., Roanoke  
Mrs. Fern N. Martin

**JACKSON COUNTY**

Phillips Nursing Home  
108 S. Pine St., Seymour  
Mrs. Effie Phillips

**Roselawn Home**

202 W. 6th St., Seymour  
Mrs. Esta T. Martin  
Roselawn Home Annex  
305 St. Louis Ave., Seymour  
Mrs. Esta T. Martin

**JAY COUNTY**

Downing Nursing Home  
124 W. North St., Portland  
Mrs. Delsie M. Downing  
Portland Nursing Home, Inc.  
406 W. Arch St., Portland  
Mrs. Mary Ellen Hearn  
Mrs. Irma Wells

**JEFFERSON COUNTY**

Lewellen Nursing Home  
421 N. Jefferson St., Madison  
Mrs. Bettie G. Lewellen and  
Mrs. Daisy Lewellen  
Madison Nursing Home  
726 W. Main St., Madison  
Mrs. Ella Shuell, R.N.  
Glore Nursing Home  
Box 31, North Madison  
Mrs. Flora Glore  
Hilltop Rest Home  
Box 67, North Madison  
Mrs. Susan Obertate

**JOHNSON COUNTY**

Janie's Nursing Home  
651 S. State St., Franklin  
Mrs. Janie Johnson  
McKee's Nursing Home  
400 Kentucky St., Franklin  
Mrs. Florence Ellen McKee  
Greenwood Hilltop Nursing  
Home  
R. R. 2, Fry Rd., Greenwood  
Mr. and Mrs. C. A. Bryant

**KNOX COUNTY**

Moore's Nursing Home  
204 W. Third St., Bicknell  
Mrs. Adeline Bernice Moore  
Compton's Nursing Home  
319-321 College Ave., Vincennes  
Miss Bertha C. Compton  
Vincennes Nursing Home  
703 Prairie St., Vincennes  
Mrs. Fern Junod  
Winterhaven Convalescent  
Home  
24 S. Seventh St., Vincennes  
Clyde W. Turner

**KOSCIUSKO COUNTY**

Bradbury Nursing Home  
P. O. Box 15, Atwood  
Mrs. Hazel Bradbury  
Dunroven Place Rest Home  
R. R. 1, Leesburg  
Mrs. Al-Aroma Green

**Alfran Nursing Home**  
R. R. 1, Road #30, Pierceton  
Frank N. Wilson and  
Alice M. Wilson, R.N.

**Armington Home**  
519 W. Winona Ave., Warsaw  
Mrs. Charles Armington

**LAGRANGE COUNTY**

**Marks Rest Home**  
739 Maple St., LaGrange  
Mrs. Marie Bertha Marks

**Maplehaven Rest Home**  
Mongoo  
Mrs. Betty L. Bennett

**LAKE COUNTY**

**Hilltop Nursing Home**  
R. R. 2, Box 159, Crown Point  
Mrs. Olive Beggs

**Shady Heights**  
R. R. 1, Dyer  
Mrs. Faye McGuire

**Beaton's Nursing Home**  
521 Pennsylvania St., Gary  
Mrs. Laura Beaton

**Calloway's Nursing Home**  
1948 Massachusetts St., Gary  
Mrs. Tomye D. Calloway

**Green's Home**  
3960 Massachusetts St., Gary  
Mrs. Lillian Green

**Miller Nursing Home**  
2301 Adams St., Gary  
Miss Ida Miller

**Sanders Nursing Home**  
1944 Maryland St., Gary  
Mrs. LaGora Sanders

**South Side Nursing Home for  
The Aged**

2481 Jefferson St., Gary  
Mrs. Margaret Morgan

**West End Convalescent Home**  
1501 Wheeler St., Gary  
Mrs. Esther G. Jones

**Gearlds Rest Home**  
726 Sibley St., Hammond  
Mrs. Vida Gearlds

**Gerrie's Nursing Home**  
6727 Baring Ave., Hammond  
Mrs. Geraldine Woodruff

**Hodge Nursing Home**  
909 State St., Hammond  
Mrs. Lucille Hodge

**LAPORTE COUNTY**

**White Tower**  
209 State St., LaPorte  
Mrs. Esther Jones  
**Helene Rest Home**  
R. R. 3, Johnson Rd., Michigan  
City  
Howard J. Prueter

**Schofield Nursing Home**  
810 E. Michigan St., Michigan  
City  
Mrs. Florence D. Schofield

**LAWRENCE COUNTY**

**Maick's Nursing Home**  
321 "L" St., Bedford  
Mrs. Minnie Maick

**Norwood Nursing Home**  
916 14th St., Bedford  
Mrs. Estella Norwood

**Stancombe Nursing Home**  
R. R. 5, Bedford  
Clifford and Pearl Stancombe

**MADISON COUNTY**

**Bradford Nursing Home**  
625 W. Adams St., Alexandria  
Mrs. Alma Bradford

**Bright Memorial Home**  
2025 Jackson St., Anderson  
Mrs. Blanche Graser

**Goble Home**  
332 W. 11th St., Anderson  
Olive and Oran Goble

**McVey Nursing Home**  
1519 W. 3rd St., Anderson  
Mrs. Stella May McVey

**Newby Nursing Home**  
1709 E. 22nd St., Anderson  
Mrs. Georgia Newby

**Rahbek Nursing Home**  
711 W. Fifth St., Anderson  
Mrs. Marie L. Rahbek

**Sanders Nursing Home**  
1403 Brown St., Anderson  
Mrs. Vera M. Sanders

**Van Dyke Nursing Home**  
2417 Pearl St., Anderson  
Mrs. Pearl M. Van Dyke

**McGuire Nursing Home**  
2224 S. "K" St., Elwood  
Mrs. Nellie Fern McGuire

**Scott's Nursing Home**  
339 Broadway, Pendleton  
Mrs. Ruby Scott

**MARION COUNTY**

**Tall Cedars**  
R. R. 1, Box 27, Bridgeport  
Mrs. Ora Miley  
**Bethel Sanitarium**  
333 N. Delaware St., Indianap-  
olis

Mrs. Mary E. Rohn  
**Booker's Convalescent Home**  
1409 Bellefontaine St., Indian-  
apolis

Mrs. Geneva Booker  
**Central Nursing Home**  
2262 Central Ave., Indianapolis  
Mrs. Bertha A. Flagle

**Christen's Nursing Home**  
1930 Sugar Grove Ave.,  
Indianapolis  
Mrs. Ethel Christen

**Conde Nursing Home**  
624 E. 12th St., Indianapolis  
Marian Niles and  
Beulah Gronlund

**Cottage Rest Home**  
46 S. Warman Ave., Indianapolis  
Mrs. Louise Wooldridge

**Del-Ray Nursing Home**  
1336 N. Delaware St., Indian-  
apolis  
Mrs. Amos Jackson

**Marie Fred Nursing Home**  
604 N. Jefferson Ave.  
Indianapolis  
Mrs. Marie Fred, R.N.

**Hillside Nursing Home**  
2370 Hillside Ave., Indianapolis  
Mrs. Ella Mason

**Hooper Nursing Home**  
1636-38 N. Illinois St.,  
Indianapolis  
Mrs. Carol Hooper

**Huff Sanitarium**  
115 S. Audubon Rd.,  
Indianapolis

Mrs. Rachel A. and  
Bettina Sullivan

**Irrington Sanitarium**  
R. R. 10, Box 320, Indianapolis  
Mrs. Minnie P. Waymire

**Jennings Nursing Home**  
942 N. Alabama St., Indianapolis  
George F. and Clara B. Jennings

**King Nursing Home**  
1907 N. Illinois St., Indianapolis  
Mrs. Henrietta Quinn

**Myrtle Lee Nursing Home**  
1429 Carrollton Ave.,  
Indianapolis

Miss Mabel Cecilia Smalley  
**Lou Wise**

2516 Central Ave., Indianapolis  
Mrs. Bessie Craig Cook

**Lovena's**  
2350 N. New Jersey St., Indian-  
apolis

Mrs. Comal L. Rosenbarger  
**Lucile Nursing Home**

616 N. Senate Ave., Indianapolis  
Mrs. Lucile Mealure

**Lynhurst Nursing Home #1**  
5225 W. Morris St., Indianapolis  
Mrs. Mabel Waldkoetter

**Martin Nursing Home**  
1621 Park Ave., Indianapolis  
Mrs. Lucille Martin

**Betty Martin Nursing Home**  
2858 N. Illinois St., Indianapolis  
Mrs. Beulah Martin

**Matthews Rest Home**  
823 Broadway, Indianapolis  
Mrs. Ethel M. Matthews

**Messer Nursing Home**  
2432 Central Ave., Indianapolis  
Calvin L. and Mary J. Messer

**Mohler Sanatorium**  
702-704 N. Alabama St.,  
Indianapolis  
John G. Harris

**Moye Nursing Home**  
2115 Central Ave., Indianapolis  
Mrs. Agnes Moye

**The Murt-McCune Nursing Home**  
1629 College Ave., Indianapolis  
Mrs. Emma Murt and Mrs. Catherine McCune  
"Northwestern"  
2413 Northwestern Ave., Indianapolis  
Mrs. Ray Puryear

**Olympia Nursing Home**  
6759 E. Washington St.,  
Indianapolis  
Mrs. Frances Limpus

**Payne's Nursing Home**  
1335 Nordyke St., Indianapolis  
Mrs. Opal Payne

**Pike Sanitarium**  
2037 N. Illinois St., Indianapolis  
Mrs. Lillian G. Pike

**Pleasant View Rest Home**  
5000 Southeastern Ave.,  
Indianapolis  
Mrs. Laura E. Weber

**Rest Haven Sanitarium**  
3245 N. Illinois St., Indianapolis  
Mrs. E. Katherine Shearer

**Robinson's Private Home #1**  
2254 Central Ave., Indianapolis  
Mrs. Eunice Robinson

**Robinson's Private Home #2**  
2250 Central Ave., Indianapolis  
Mrs. Eunice Robinson

**Rose Lawn Home**  
1408 N. Pennsylvania St.,  
Indianapolis  
Mrs. Lucy V. Connor

**Springer's Nursing Home**  
6566 W. Washington St., Indianapolis  
Millard and Gladys Springer

**Suddarth Nursing Home**  
1445 Broadway, Indianapolis  
Mrs. Cleo Suddarth

**Sunshine Nursing Home**  
4416 E. Washington St.,  
Indianapolis  
Mrs. Ethel M. Bills

**Vollmer Convalescent Home**  
2630 College Ave., Indianapolis  
Mr. Emory H. Vollmer

**Mrs. Waddle's Private Home**  
2112 N. Delaware St.,  
Indianapolis  
Mrs. Mable S. Waddle

**Ward Nursing Home**  
1518 N. Senate Ave.,  
Indianapolis  
Mrs. Willa Mae Murray

**Weber Convalescing Home**  
43 S. Ritter Ave., Indianapolis  
Mrs. Laura E. Weber

**West Park Home**  
373 N. Holmes Ave.,  
Indianapolis  
Mrs. Mary R. Frame

**Wildwood Restorium**  
895 Middle Dr., Woodruff Place,  
Indianapolis  
Mrs. Nellie Wildman

#### MARSHALL COUNTY

**Bair Convalescent Home**  
801 N. Main St., Bourbon  
Mrs. Kathryn M. Hepler, R.N.

**Austin Nursing Home**  
821 Angell St., Plymouth  
Mrs. Mabel M. Austin

**Sherman Nursing Home**  
203 Pennsylvania Ave.,  
Plymouth  
Mrs. Vesta K. Sherman

#### MIAMI COUNTY

**Barnes Nursing Home**  
224 W. 10th St., Peru  
Mrs. Charlotte Barnes

**The Miami Home**  
77 E. Third St., Peru  
Mrs. Kathryn Tom

**Peru Nursing Home**  
906 W. Main St., Peru  
Mrs. Helen Watson and  
Mrs. Marguerite Donat

**Redmon Nursing Home**  
225 W. 10th St., Peru  
Mrs. Lola Redmon

#### MONROE COUNTY

**Fagan Nursing Home**  
R. R. 4, Bloomington  
Mrs. Ida B. Fagan

**Parrott Nursing Home**  
115 S. Lincoln St., Bloomington  
Miss Mary Gwendolia Parrott,  
R.N.

**Percifield Nursing Home**  
1031 W. 6th St., Bloomington  
Mrs. Myrtle D. Percifield

**Polley Nursing Home**  
705 W. 4th St., Bloomington  
Mrs. Elsie Mae Polley

**Wilkins Nursing Home**  
1023 E. 10th St., Bloomington  
Mrs. Orpha Wilkins

#### MONTGOMERY COUNTY

**Hart Memorial Home and Annex**  
R. R. 1, Crawfordsville  
Mrs. Myrtle Johnson

**Liter Nursing Home**  
1304 S. Grant Ave., Crawfordsville  
Mrs. Marie Liter Dienhart

**Shahan Nursing Home**  
613 Kentucky St.,  
Crawfordsville  
Miss Eileen M. Shahan

**Hazel Small Rest Home**  
N. Vine St., Waynetown  
Mrs. Hazel Small

#### MORGAN COUNTY

**Cherry Nursing Home**  
60 E. Harrison St., Crawfordsville  
Mrs. Zepha Cherry

#### NOBLE COUNTY

**Golden Rule Nursing Home**  
R. R. 1, Pierceton  
Mr. and Mrs. H. F. Mock

#### OHIO COUNTY

**Galbreath Home**  
Fourth St., Rising Sun  
Mrs. Effie Galbreath

#### ORANGE COUNTY

**The Gorge Retreat and Sanitarium**  
R. R. 2, Box 228, French Lick  
Gertrude Haynes, R.N. and  
Myrtle Simpson, R.N.

#### OWEN COUNTY

**Gosport Nursing Home**  
W. Main St., Gosport  
Mrs. Mary Wampler

**Jones Nursing Home**  
379 Hillside Ave., Spencer  
Mr. and Mrs. Boyd Jones

**Reapp Nursing Home**  
Greencastle Rd., Spencer  
Mrs. Jennie C. Reapp

#### PARKE COUNTY

**Wallace Nursing Home**  
517 W. Ohio St., Rockville  
Mrs. Evelyn Wallace

**Allen Nursing Home**  
Madison St., Montezuma  
Mrs. Sylvia Allen

#### PIKE COUNTY

**Fay's Convalescent Home**  
210 S. 14th St., Petersburg  
Mrs. Fay France

**Riddle Nursing Home**  
411 Walnut St., Petersburg  
Mrs. Alice M. Riddle



**PORTER COUNTY**

**Beverly Shores Rest Home, Inc.**  
Beverly Shores  
Samuel Robert Barker, M.D.  
**Wood Nursing Home**  
R. R. 2, West Dunes Highway,  
Michigan City  
Mrs. Helen O. Wood  
**Wood Nursing Home Annex**  
R. R. 2, Dunes Highway, Mich-  
igan City  
Mrs. Helen O. Wood  
**Valparaiso Nursing Home**  
359 Greenwich St., Valparaiso  
Mr. and Mrs. Orel J. Goble

**POSEY COUNTY**

**Allison Nursing Home**  
Locust St., Poseyville  
Mrs. Lula Allison

**PUTNAM COUNTY**

**Ruark Nursing Home**  
R. R. 1, Fillmore  
Mrs. Elsie Cowgill Ruark  
**Craver Home**  
Avenue E, Box 15, Greencastle  
Mrs. Hannah Craver  
**Donna Nursing Home**  
416 E. Hanna St., Greencastle  
Mrs. Mildred Brown

**RANDOLPH COUNTY**

**The Ideal Rest Home**  
104 S. Cherry St., Lynn  
Mrs. Blanche E. Allender  
**Lamb's Nursing Home**  
R. R. 4, Union City  
Mrs. Bernice A. Lamb  
**Shady Lawn Nursing Home**  
R. R. 3, Winchester  
Mrs. Marjorie Stewart

**RIPLEY COUNTY**

**The Conyer's Convalescent Home**  
Milan  
Mrs. Mary Colson  
**The Milan Homestead**  
Milan  
Mrs. Mary Colson  
**Rick Nursing Home**  
R. R. 1, Milan  
Mrs. Inas Tobrock Rick  
**Gilland Nursing Home**  
310 Craven St., Osgood  
Mr. and Mrs. Dan Gilland  
**Elsie Dreyer Nursing Home**  
Main St., Sunman  
Miss Elsie Dreyer  
**Mary Dreyer Nursing Home**  
South Main St., Sunman  
Mrs. Mary Dreyer

**RUSH COUNTY**

**Clark Nursing Home**  
230 E. 7th St., Rushville  
Mrs. Harry Clark

**Clifton Nursing Home #1**  
204 W. Third St., Rushville  
Mrs. Mary Clifton  
**Clifton Nursing Home #2**  
R. R. 1, (Circleville), Rushville  
Mrs. Mary Clifton  
**Cohee Rest Home**  
314 E. 10th St., Rushville  
Mrs. Harvey Cohee  
**Jackson Nursing Home**  
114 E. 5th St., Rushville  
Mrs. Goldie C. Jackson  
**Rushville Nursing Home**  
321 N. Morgan St., Rushville  
Mrs. Marjorie Fordyce

**SHELBY COUNTY**

**Maples Convalescent Home**  
R. R. 1, Fountaintown  
Mr. and Mrs. William McGraw  
**Land's Nursing Home**  
Morristown  
Ida and Elbert Land  
**Land's Nursing Home**  
306 Howard St., Shelbyville  
Mrs. Ida Land  
**Waldron Nursing Home**  
Main Street, Waldron  
Mrs. Evelyn Nasby, R.N.

**SPENCER COUNTY**

**Mayhall Nursing Home**  
417 S. 6th St., Rockport  
Mrs. Alice R. Mayhall

**ST. JOSEPH COUNTY**

**The Copenhagen**  
914 W. Fourth St., Mishawaka  
Mrs. June Copenhagen  
**Emerick Home**  
910 W. 4th St., Mishawaka  
Mrs. Ila Mae Emerick  
**Krogh Nursing Home**  
109 N. Cedar St., Mishawaka  
Mrs. Doris Irene Klapp  
**Burbridge Home**  
1217 S. Michigan St., South Bend  
Mrs. Catherine A. Burbridge  
**Dor-A-Lin Convalescent Home**  
1024 N. Notre Dame Ave.,  
South Bend  
Mr. and Mrs. Franklin W.  
Finkenbinder  
**Frame's Nursing Home**  
1526 Lincoln Way West,  
South Bend  
Mrs. Myrtle Frame  
**Grove Nursing Home**  
601 N. Main St., South Bend  
Mrs. Fern Grove  
**Vera-Lee Home**  
702 S. Columbia St., South Bend  
Mrs. Vera Jones and E. L.  
Finkenbinder

**Lerch Nursing Home**  
1044 Lincoln Way, West, South  
Bend  
Mrs. Katherine B. Lerch  
**Whiteman Nursing Home**  
1145 Napier St., South Bend  
Mrs. Betty Whiteman  
**Waldron Nursing Home**  
500 Roosevelt Rd., Walkerton  
Mrs. Virginia Waldron

**STARKE COUNTY**

**Ruff Nursing Home**  
75 W. John St., Knox  
Mrs. Alcinda Ruff

**STEBEN COUNTY**

**Angola Rest Home, Inc.**  
306 N. Wayne St., Angola  
Mrs. Ruth G. Libby  
**Edith Nursing Home**  
116 N. Powers St., Angola  
Miss Lois Adams

**TIPPECANOE COUNTY**

**Laura M. Bowles Convalescent Home**  
Clarks Hill  
Mrs. Laura M. Bowles  
**Burnett's**  
221 S. 9th St., Lafayette  
Mrs. Maude L. Golden  
**Cheesman Nursing Home**  
1021 N. 7th St., Lafayette  
Mrs. Addie V. Cheesman  
**Scott Nursing Home for Men**  
614 N. 8th St., Lafayette  
Mr. Howard F. Scott  
**Scott Nursing Home for Women**  
1100 N. 9th St., Lafayette  
Mrs. Goldie Scott

**TIPTON COUNTY**

**Simmons Nursing Home**  
325 N. West St., Tipton  
Mr. and Mrs. Ernest Simmons  
**UNION COUNTY**  
**Scott Nursing Home**  
302 W. Union St., Liberty  
Mrs. Anna Scott

**VANDERBURGH COUNTY**

**Bethany Rest Home**  
316 N. Wabash Ave., Evansville  
Mrs. Edith Poole Masterson  
**Comfort Rest Home**  
1317 S. E. Second St.  
Evansville  
Mrs. Viola Barnes  
**Dorsey Nursing Home**  
1714 S. Governor St., Evansville  
Mrs. Laura Dorsey  
**Evans Nursing Home**  
605 Oak St., Evansville  
Mrs. Anna Evans  
**Fulton Rest Home**  
1328 N. Fulton Ave., Evansville  
Mrs. Grace L. Richter

**Gee's Rest Haven**  
807 S. E. Third St.  
Evansville  
Mrs. Leona Gee

**Jarrett Convalescent Home**  
605 Oakley St., Evansville  
Mrs. Lena K. Jarrett

**Kueber Nursing Home**  
816 First Ave., Evansville  
Mrs. Catherine Kueber

**M & R Nursing Home**  
1100 N. Read St., Evansville  
Mrs. Muriel B. Sprinkle

**Maxey Nursing Home**  
909 First Ave., Evansville  
Mr. and Mrs. Pearlless Maxey

**The Newton Rest Home**  
923 S. Elliott St., Evansville  
Mrs. Gwendolyn Newton

**Pleasant Nursing Home**  
109 W. Maryland St., Evansville  
Mrs. Maryetta Morris

**Ingle Smith Home**  
521 S. E. First St., Evansville  
Mrs. Della Ingle Smith, R.N.

**Stinson Rest Home**  
315 S. E. Second St., Evansville  
Mrs. Mildred Stinson

**Taylor Nursing Home**  
915 W. Bond St., Evansville  
Mrs. Juanita Taylor

**Tindall Rest Home**  
218 Harriett St., Evansville  
Mrs. Dorothy Tindall Pennington

**Ulbricht Rest Home**  
616 W. Franklin St., Evansville  
Mrs. Martha Ulbricht

**Wells Nursing Home**  
916 W. Michigan St., Evansville  
Mrs. Ada Wells

**VIGO COUNTY**

**Calvary Nursing Home**  
421 N. Fifth St., Terre Haute  
Mrs. Oakie Lawson

**Cook Nursing Home**  
2058 N. 7th St., Terre Haute  
Mrs. Grace E. Cook

**Foos Nursing Home**  
418 S. 8th St., Terre Haute  
Mrs. Lydia E. Foos

**Gano Nursing Home**  
501 N. 4th St., Terre Haute  
Mrs. Anna Gano

**Hatfield Nursing Home**  
2111 N. 13½ St., Terre Haute  
Mrs. Eliza Hatfield

**Hise Nursing Home**  
120 N. 12th St., Terre Haute  
Mrs. Lillie Hise

**Kesler's Nursing Home**  
724 N. 8th St., Terre Haute  
Mrs. Clara A. Kesler

**Mary Etta Nursing Home**  
241 N. 13th St., Terre Haute  
Mrs. Mamie Mason

**Mrs. Barney Pigg Nursing Home**  
1334 Sycamore St.  
Terre Haute  
Mrs. Barney Pigg

**Sharps Nursing Home**  
1518 N. Center, Terre Haute  
Mrs. Hazel M. Sharps

**Smith Nursing Home**  
202 N. 23rd St., Terre Haute  
Mrs. Edith C. Smith

**Sullivan Nursing Home**  
705 S. 7th St., Terre Haute  
Mrs. Grace F. Sullivan

**Trainer Nursing Home**  
1915 N. 11th St., Terre Haute  
Mrs. Geneva Trainer

**WABASH COUNTY**

**The Pilgrim Nursing Home**  
306 E. 4th St., North Manchester  
Mrs. Pearl Lambert

**Dunfee Nursing Home**  
1250 Pike St., Wabash  
Mrs. Florence Dunfee

**Moss Nursing Home**  
855 Ferry St., Wabash  
Mrs. Irene Moss

**WARRICK COUNTY**

**Hollis Nursing Home**  
R. R. 5, Boonville  
Mrs. Loraine Hollis

**Hollis Nursing Home #2**  
R. R. 5, Boonville  
Mrs. Loraine Hollis

**WASHINGTON COUNTY**

**Williams Nursing Home**  
R. R. 3, Scottsburg  
Mrs. Kathleen Williams

**WAYNE COUNTY**

**Bowman's Rest Home**  
444 W. Main St., Cambridge City  
Mrs. Esther Bowman

**Aldora Nursing Home**  
R. R. 1, Centerville  
Mr. and Mrs. Alwin Carlton

**Pinehurst Nursing Home**  
R. R. 1, Centerville  
Mrs. Gertrude E. Johnson

**Twin Pines Nursing Home**  
Main St., Economy  
Marguerite C. Potts

**Reynolds Convalescent Home**  
R. R. 2, Hagerstown  
Mrs. Adeline Reynolds

**Gains Nursing Home #1**  
R. R. 2, Box 448, Richmond  
Mrs. Emma Gains

**Gains Nursing Home #2**  
R. R. 2, Box 448, Richmond  
Mrs. Emma Gains

**Gains Nursing Home No. 3**  
R. R. 2, Box 448, Richmond  
Mrs. Emma Gains

**Jennie Hartman Nursing Home**  
139 S. E. 14th St., Richmond  
Mrs. Jennie Hartman

**WELLS COUNTY**

**Davis Nursing Home**  
627 S. Marion St., Bluffton  
Mrs. I. Helen Davis

**Clark's Nursing Home**  
522 E. South St., Bluffton  
Mrs. Clara Clark

**Cooper Rest Home**  
306 W. Wabash St., Bluffton  
Mrs. Janet Cooper, R.N.

**Southview Rest Home**  
R. R. 3, Bluffton  
Mrs. Cora N. Anderson

**WHITLEY COUNTY**

**Farris Nursing Home**  
209 W. Market St.,  
Columbia City  
Mrs. Louise Farris

**Irvin Nursing Home**  
604 W. Van Buren St.,  
Columbia City  
Mrs. Marguerite Irvin

**South Whitley Rest Home, Inc.**  
306 Columbia St., South Whitley  
Robert E. Bresnahan and Katherine A. Bresnahan, R.N.

INDIANA UNIVERSITY SCHOOL OF MEDICINE

1040 W. Michigan Street, Indianapolis

John D. Van Nuys, M.D., Indianapolis—Dean

HEADS OF DEPARTMENTS

- Department of Anatomy—Richard L. Webb, Ph.D., Bloomington.
- Department of Physiology — Paul M. Harmon, Ph.D., Bloomington.
- Department of Biochemistry and Pharmacology—Rolla N. Harger, Ph.D., Indianapolis.
- Department of Public Health—(Open)
- Department of General Pathology — Edward B. Smith, M.D., Indianapolis.
- Department of Microbiology—Edward W. Shrigley, M.D., Ph.D., Indianapolis.
- Department of Clinical Pathology—C. G. Culbertson, M.D., Indianapolis.
- Department of Orthopedic Surgery—George Garceau, M.D., Indianapolis.
- Department of Surgery — Harris B. Shumacker, Jr., M.D., Indianapolis.
- Department of Medicine—J. O. Ritchey, M.D., Indianapolis.
- Department of Neurology — Alexander T. Ross, M.D., Indianapolis.
- Department of Psychiatry—(Open)
- Department of Radiology — Raymond C. Beeler, M.D., Indianapolis.

- Department of Obstetrics and Gynecology—Carl P. Huber, M.D., Indianapolis.
- Department of Dermatology and Syphilology—Frank M. Gastineau, M.D., Indianapolis.
- Department of Otorhinolaryngology and Bronchoesophagology—Marlow Manion, M.D., Indianapolis.
- Department of Ophthalmology—Fred M. Wilson, M.D., Indianapolis.
- Department of Genito-Urinary Surgery — H. O. Mertz, M.D., Indianapolis.
- Department of Pediatrics—Lyman T. Meiks, M.D., Indianapolis.
- Department of Anesthesiology—Virgil K. Stoeltling, M.D., Indianapolis.
- Department of Medical Economics and Post Graduate Instruction—(Open)

INDIANA UNIVERSITY MEDICAL CENTER  
1040-1232 W. Michigan Street  
Indianapolis

- Administrator—Mr. Edmund J. Shea.
- Medical Director—David A. McKinley, M.D.
- Director of Clinical Laboratories—J. L. Arbogast, M.D.
- Chief Radiologist—J. A. Campbell, M.D.

ACCREDITED SCHOOLS OF NURSING

School of Nursing and Hospital, University or College with which School is connected		Location	Director, School of Nursing	Daily Patient Census
*a	St. John's Hickey Memorial	Anderson	Sister Anne Miriam, R.N.	206
	Protestant Deaconess	Evansville	Miss Elsie Norman, R.N.	238.8
	St. Mary's	Evansville	Sister Georgiana, R.N.	154.5
	Welborn Memorial Baptist	Evansville	Mrs. Madeline T. Kinney, R.N.	114
a	Lutheran	Fort Wayne	Miss Myrtle E. Lewis, R.N.	200
	Methodist	Fort Wayne	Miss Marie Kolter, R.N.	110
	St. Joseph	Fort Wayne	Sister M. Theodorita, R.N.	255.5
	Methodist <sup>1</sup>	Gary	Miss Marcia J. Aitkens, R.N.	242
	St. Mary Mercy <sup>1</sup>	Gary	Sister M. Cornelia, R.N.	212
xxxb	Goshen College	Goshen	Miss Orpah B. Mosemann, R.N., Act'g.	
	St. Margaret <sup>1</sup>	Hammond	Sister M. Florianne, R.N.	238
a	Indiana University	Indianapolis	Miss Jean L. Coffey, R.N.	536
a	Indianapolis General	Indianapolis	Mrs. Edna Carter Wilson, R.N.	562
b	Methodist	Indianapolis	Miss Fredericka E. Koch, R.N.	637.5
	St. Vincent's	Indianapolis	Sister Clare, R.N.	318



*a Good Samaritan School,		
St. Joseph Memorial Hospital	Kokomo	Sister M. Bernadette, R.N. 140
Lafayette Home	Lafayette	Miss Lucille H. Johnson, R.N. 111.4
a St. Elizabeth <sup>1</sup>	Lafayette	Sister M. Florina, R.N. 224
Ball Memorial	Muncie	Miss Janet Froome, R.N. 265.5
a Holy Cross Central School	Notre Dame	Sister M. Amadeo, R.N.
Hospital Units:		
St. John's Hickey Memorial		
Hospital	Anderson	206
St. Joseph Hospital	Kokomo	140
St. Joseph Hospital	South Bend	144
St. Mary's Hospital	Cairo, Illinois	65
Our Savior's Hospital	Jacksonville, Illinois	76
xxxxa St. Mary's College	Notre Dame	Sister M. Amadeo, R.N.
Reid Memorial	Richmond	Miss Prudence Appelman, R. N. 138
Memorial Hospital <sup>1</sup>	South Bend	Miss Florence Young, R.N. 202
*a St. Joseph's	South Bend	Sister M. Cecilian, R.N. 144
a St. Anthony	Terre Haute	Sister M. Delphina, R.N. 156
Union	Terre Haute	Miss Ellen R. Church, R.N. 158
Good Samaritan	Vincennes	Miss Faith Smith, R.N. 190

a Negro students are enrolled.

b will accept male students.

\* students are admitted through Holy Cross Central School.

xxx collegiate school of nursing.

1—Temporarily accredited—1953.

# PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served	Name and Residence	Elected	Served
<b>Medical Convention</b>					
*Livingston Dunlap, Indianapolis-----	1849	1849	*William N. Wishard, Indianapolis----	1897	1898
<b>Medical Society</b>			*John C. Sexton, Rushville-----	1898	1899
*William T. S. Cornett, Versailles-----	1849	1850	*Walker Schell, Terre Haute-----	1899	1900
*Ashahel Clapp, New Albany-----	1850	1851	*George W. McCaskey, Ft. Wayne----	1900	1901
*George W. Mears, Indianapolis-----	1851	1852	*Alembert W. Brayton, Indianapolis--	1901	1902
*Jeremiah H. Brower, Lawrenceburg--	1852	1853	*John B. Berteling, South Bend-----	1902	1903
*Elizur H. Deming, Lafayette-----	1853	1854	<b>Medical Association</b>		
*Madison J. Bray, Evansville-----	1854	1855	*Jonas Stewart, Anderson-----	1903	1904
*William Lomax, Marion-----	1855	1856	*George T. MacCoy, Columbus-----	1904	1905
*Daniel Meeker, LaPorte-----	1856	1857	*George H. Grant, Richmond-----	1905	1906
*Talbot Bullard, Indianapolis-----	1857	1858	*George J. Cook, Indianapolis-----	1906	1907
*Nathan Johnson, Cambridge City-----	1858	1859	*David C. Peyton, Jeffersonville-----	1907	1908
*David Hutchinson, Mooresville-----	1859	1860	*George D. Kahlo, French Lick-----	1908	1909
*Benjamin S. Woodworth, Ft. Wayne	1860	1861	*Thomas C. Kennedy, Shelbyville-----	1909	1910
*Theophilus Parvin, Indianapolis-----	1861	1862	*Frederick C. Heath, Indianapolis--	1910	1911
*James F. Hibberd, Richmond-----	1862	1863	*William F. Howat, Hammond-----	1911	1912
*John Sloan, New Albany-----	1863	----	*A. C. Kimberlin, Indianapolis-----	1912	1913
*John Moffett (acting), Rushville-----	1863	1864	*John P. Salb, Jasper-----	1913	1914
*Samuel L. Linton, Columbus-----	1864	----	*Frank B. Wynn, Indianapolis-----	1914	1915
*Wilson Lockhart (acting), Danville--	1864	1865	*George F. Keiper, Lafayette-----	1915	1916
*Myron H. Harding, Lawrenceburg--	1865	1866	*John H. Oliver, Indianapolis-----	1916	1917
*Vierling Kersey, Richmond-----	1866	1867	*Joseph Rilus Eastman, Indianapolis--	1917	1918
*John S. Bobbs, Indianapolis-----	1867	1868	William H. Stemm, North Vernon----	1918	1919
*Nathaniel Field, Jeffersonville-----	1868	1869	*Charles H. McCully, Logansport-----	1919	1920
*George Sutton, Aurora-----	1869	1870	*David Ross, Indianapolis-----	1920	1921
*Robert N. Todd, Indianapolis-----	1870	1871	*William R. Davidson, Evansville-----	1921	1922
*Henry P. Ayres, Ft. Wayne-----	1871	1872	*Charles H. Good, Huntington-----	1922	1923
*Joel Pennington, Milton-----	1872	1873	*Samuel E. Earp, Indianapolis-----	1923	1924
*Isaac Casselberry, Evansville-----	1873	----	Eldridge M. Shanklin, Hammond-----	1924	1925
*Wilson Hobbs (acting), Knights- town-----	1873	1874	Charles N. Combs, Terre Haute-----	1925	1926
*Richard E. Houghton, Richmond-----	1874	1875	*Frank W. Cregor, Indianapolis-----	1926	1927
*John H. Helm, Peru-----	1875	1876	George R. Daniels, Marion-----	1926	1928
*Samuel S. Boyd, Dublin-----	1876	1877	Charles E. Gillespie, Seymour-----	1927	1929
*Luther D. Waterman, Indianapolis--	1877	1878	*Angus C. McDonald, Warsaw-----	1928	1930
*Louis Humphreys, South Bend-----	1878	----	*Alois B. Graham, Indianapolis-----	1929	1931
*Benj. Newland (acting), Bedford (v.p.)-----	1878	1879	Franklin S. Crockett, Lafayette-----	1930	1932
*Jacob R. Weist, Richmond-----	1879	1880	*Joseph H. Weinstein, Terre Haute--	1931	1933
*Thomas B. Harvey, Indianapolis-----	1880	1881	*Everett E. Padgett, Indianapolis-----	1932	1934
*Marshall Sexton, Rushville-----	1881	1882	*Walter J. Leach, New Albany-----	1933	1935
*William H. Bell, Logansport-----	1882	1883	Roscoe L. Sensenich, South Bend...	1934	1936
*Samuel E. Mumford, Princeton-----	1883	1884	*Edmund D. Clark, Indianapolis-----	1935	1937
*James H. Woodburn, Indianapolis-----	1884	1885	Herman M. Baker, Evansville-----	1936	1938
*James S. Gregg, Ft. Wayne-----	1885	1886	*Edmund M. Van Buskirk, Ft. Wayne--	1937	1939
*General W. H. Kemper, Muncie-----	1886	1887	Karl R. Ruddell, Indianapolis-----	1938	1940
*Samuel H. Charlton, Seymour-----	1887	1888	*Albert M. Mitchell, Terre Haute-----	1939	1941
*William H. Wishard, Indianapolis-----	1888	1889	Maynard A. Austin, Anderson-----	1940	1942
*James D. Gatch, Lawrenceburg-----	1889	1890	Carl H. McCaskey, Indianapolis-----	1941	1943
*Gonsolvo C. Smythe, Greencastle-----	1890	1891	*Jacob T. Oliphant, Farmersburg-----	1942	1944
*Edwin Walker, Evansville-----	1891	1892	Neslen K. Forster, Hammond-----	1943	1945
*George F. Beasley, Lafayette-----	1892	1893	*Jesse E. Ferrell, Fortville-----	1944	1946
*Charles A. Daugherty, South Bend..	1893	1894	*Floyd T. Romberger, Lafayette-----	1945	1947
*Elijah S. Elder, Indianapolis-----	1894	----	Cleon A. Nafe, Indianapolis-----	1946	1948
Charles S. Bond (acting), Richmond	1894	1895	Augustus P. Hauss, New Albany-----	1947	1949
*Miles F. Porter, Ft. Wayne-----	1895	1896	C. S. Black, Warren-----	1948	1950
*James H. Ford, Wabash-----	1896	1897	Alfred Ellison, South Bend-----	1949	1951
			J. William Wright, Indianapolis-----	1950	1952
			Paul D. Crimm, Evansville-----	1951	1953
			Wm. Harry Howard, Hammond-----	1952	1954

\*Deceased.

# Constitution and By-Laws

## of the

### Indiana State Medical Association

#### CONSTITUTION

##### ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

##### ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

##### ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

##### ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

**Section 1.**—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

**Sec. 2.—Active Members.**—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

**Sec. 3.—Associate Members.**—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

**Sec. 4.—Senior Members.**—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such member-

ship by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

**Sec. 5.—Honorary Members.**—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

**Sec. 6.—Rights and Privileges of Members.**—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

##### ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

##### ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge



and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

#### ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

#### ARTICLE VIII.—CONVENTION AND MEETINGS

**Section 1.**—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

**Sec. 2.**—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

**Sec. 3.**—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

#### ARTICLE IX.—OFFICERS

**Section 1.**—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

**Sec. 2.**—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secre-

tary shall thereupon take action in accordance with Section 4 of this article.

**Sec. 3.**—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

**Sec. 4.**—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

**Sec. 5.**—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.
2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.
3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

**Sec. 6.**—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

**Sec. 7.**—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

**Sec. 8.**—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

**Sec. 9.**—None of the officers shall receive compensation except the Executive Secretary, who

shall be employed by the Council, and the Council shall fill any vacancy in that office.

#### ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

#### ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

#### ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

#### ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

#### ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the

delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

### BY-LAWS

#### CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these By-Laws unless otherwise indicated shall mean both active and senior members.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

#### CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President shall be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the



Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

**Sec. 4.**—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Committee on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

#### CHAPTER III.—SECTIONS

**Section 1.**—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Medical.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. General Practice.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Any other sections that hereafter may be provided for by the House of Delegates.

**Sec. 2.**—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

**Sec. 3.**—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

**Sec. 4.**—No section meeting shall be allowed to conflict with a general meeting.

#### CHAPTER IV.—HOUSE OF DELEGATES

**Section 1.**—The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as pos-

sible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

**Sec. 2.**—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county.

The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before December first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

**Sec. 3.**—Fifty delegates shall constitute a quorum.

**Sec. 4.**—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.



d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5. — Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action:

Provided, that this sub-section of the By-Laws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

#### CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

#### CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the

state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

#### CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings

of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates.

**Sec. 2.** — Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of *THE JOURNAL* which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

**Sec. 3.**—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

**Sec. 4.**—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

**Sec. 5.**—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

**Sec. 6.**—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

**Sec. 7.**—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

**Sec. 8.**—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

**Sec. 9.**—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

**Sec. 10.**—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of *THE JOURNAL* which immediately precedes the Annual Convention.

**Sec. 11.**—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

**Sec. 12.**—The Council shall elect two members of the Association, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

#### CHAPTER VIII.—STANDING COMMITTEES

**Section 1.**—The standing committees shall be as follows:

The Executive Committee.

Board of Appeals on Patient-Physician Relations.

A Committee on Convention Arrangements.



A Committee on Conference of County Medical Society Officers.

A Committee on Scientific Work.

A Committee on Scientific Exhibits.

A Committee on Public Policy and Legislation.

A Committee on Publicity.

A Committee on Industrial Health.

A Committee on Medical Education and Hospitals.

A Committee on Public Relations.

A Committee on Constitution and By-Laws.

A Committee on Rural Health.

Such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

All members of committees shall serve for one year unless otherwise specified in these By-Laws or in the authorization for appointment.

Sec. 2.—*The Executive Committee*, consisting of six members as heretofore provided for shall meet on the call of the Chairman or of any three members with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Association. It shall represent the Council during the intervals between meetings of that body, including matters pertaining to THE JOURNAL of the Association, and shall report its doings to the Council.

It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and By-Laws shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Sec. 3.—*The Committee on Convention Arrangements* shall consist of five or more members. With the advice and assistance of the Executive Secretary this committee shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its chairman shall report

an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4.—*The Committee on Scientific Work* shall consist of three or more appointive members appointed by the President; and of the chairman of the Committee on Scientific Exhibits and of the chairman of the sections as *ex officio* members. It shall be the duty of the officers of the various sections to prepare and submit to this committee prior to the first meeting of the committee a suggested program of subjects and personnel for their respective section programs for the Annual Convention. The scientific program and the financial requirements to provide for it must be approved by the Executive Committee before the program is officially announced.

Sec. 5.—*The Committee on Scientific Exhibits* shall consist of five or more appointive members. It shall have the duty of arranging for scientific exhibits as a part of the Annual Convention, subject to the approval of the Executive Committee.

Sec. 6.—*The Committee on Public Policy and Legislation* shall consist of at least five or more appointive members. Under direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine, and the improvement of the medical profession. It shall keep in touch with professional and public opinion and shall endeavor to create and direct public opinion to the end that the public will demand adequate legislation for the promotion of the public good in relation to medicine and the enforcement of such legislation.

Sec. 7.—*The Committee on Publicity* shall consist of three appointive members. It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, and for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 8.—*The Committee on Industrial Health* shall consist of five or more appointive members. The duties of the committee shall be: To study and gather facts and become intimately acquainted with the problems regarding industrial health, including any such problems as those relating to the prevention and cure of industrial injuries and diseases; to study the method and means of providing adequate medical and hospital care for



those suffering from industrial diseases and injuries; and to encourage cooperation and mutual understanding among the members of the medical profession, employers of labor, employees and insurance carriers.

**Sec. 9.**—*The Committee on Medical Education and Hospitals* shall consist of five appointive members. The duties of this committee shall be to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to cooperate with the Hospital Council of the Indiana State Board of Health in connection with the making and recommending of rules and regulations for the management of hospitals; to select one of its own members as a delegate to the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

**Sec. 10.**—*The Committee on Public Relations* shall consist of five or more appointive members. The duties of the committee shall be to develop and carry on continuously a program to improve and sustain good will among the members of the medical profession and the general public; to study and assemble information regarding the means by which the interests of the public relations of the medical profession may best be served; to obtain through public and professional contacts and report to the profession through proper means information regarding the sentiments, criticism and suggestions for improvement which may be made either by members of the profession or by the lay public; and to have the special responsibility of furnishing leadership and guidance in keeping the medical profession as a whole within the deserved respect and esteem of the people.

**Sec. 11.**—*The Committee on Constitution and By-Laws* shall consist of five appointive members. The duties of this committee shall be: to keep in contact with the developments and changes in procedures in carrying on the work of this Association; to suggest revisions necessary to keep the Constitution and By-Laws always in accord with the practices and procedures best adapted to the functioning of the Association; and to keep the practices and procedures consistent with the provisions from time to time contained in the Constitution and By-Laws—to the end that all members of the profession, by reference to the Constitution and By-Laws, may be able to obtain accurate information regarding procedure and practices within the Association, and that hampering of such

procedure and practice by obsolete provisions in the Constitution and By-Laws may be avoided.

**Sec. 12.**—*The Committee on Conference of County Medical Society Officers* shall consist of seven appointive members. It shall have the duty of arranging for conferences of County Medical Society Officers, preparing the agenda therefor, and fixing the time and place for such meetings.

**Sec. 13.**—A standing committee to be known as "The Board of Appeals on Patient-Physician Relations" shall be composed of nine physicians, three of whom shall be past presidents of the association, and all of whom shall be appointed by the president of the association. Not more than one physician shall be appointed from any one Councilor District. No member shall hold any elective office in the state association during tenure on this committee. Of the nine physicians first appointed, three, including one past president, shall serve for a period of one year; three, including one past president, for two years; three, including one past president, for three years. Thereafter three shall be appointed each year for a three year term, to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee other than by expiration of terms shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, vice-chairman, and secretary.

**Sec. 14.**—The duties of this Board of Appeals on Patient-Physician Relations shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians. It may, if it believes the facts justify such action, cite the member to the Council of the state association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing the procedure and official actions of the Board.

**Sec. 15.**—The President and Executive Secretary shall be *ex officio* members of all the foregoing standing Committees where their inclusion on the committee is not otherwise provided for in these By-Laws.

#### CHAPTER IX.—SPECIAL COMMITTEES

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

## CHAPTER X.—REFERENCE COMMITTEES

**Section 1.**—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in *THE JOURNAL* and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

**Sec. 2.**—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

- (1) Sections and Section Work
- (2) Rules and Order of Business
- (3) Medical Education and Hospitals
- (4) Legislation
- (5) Public Relations
- (6) Hygiene and Public Health
- (7) Amendments to the Constitution and By-Laws
- (8) Reports of Officers
- (9) Credentials
- (10) Insurance
- (11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many reference committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee which the President deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

**Sec. 3.**—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

## CHAPTER XI.—COUNTY SOCIETIES

**Section 1.**—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

**Sec. 2.**—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

**Sec. 3.**—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

**Sec. 4.**—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

**Sec. 5.**—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

**Sec. 6.**—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

**Sec. 7.**—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the



membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society, shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and *payable in advance*. The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward

to the Executive Secretary of this Association the dues for such new members. The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay \$10.00 as dues for the remainder of that year. Interns and residents shall pay \$10.00 a year annual dues during their term of service in the hospital. In the event the county society remits a member's dues for good cause, and the secretary of the county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

#### CHAPTER XII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

#### CHAPTER XIII.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.



Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This committee shall have full authority governing all matters pertaining to the medical defense features of this Association; with power to enter into agreement for the payment of fees of one attorney whom the physician sued shall have the right to choose, provided such attorney is of good reputation and standing at the bar, and to employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought; provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

#### CHAPTER XIV.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission

paying directly or indirectly, and any member found guilty shall be expelled from membership.

#### CHAPTER XV.—INVESTMENT OF SURPLUS FUNDS

Section 1.—All surplus funds of this association shall hereafter be invested only in United States Government bonds or in municipal bonds which the United States Government or the municipalities

issuing such bonds shall have the direct obligation to pay.

#### CHAPTER XVI.—AMENDMENTS

Section 1.—These By-Laws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and By-Laws all previous Constitutions and By-Laws are hereby repealed.

## Principals of Medical Ethics of the American Medical Association

#### PREAMBLE

These principles are intended to serve the physician as a guide to ethical conduct as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. They provide a sound basis for solution of many of the problems which arise in his relationship with patients, with other physicians, and with the public. They are not immutable laws to govern the physician. The ethical practitioner needs no such laws; rather they are standards by which he may determine the propriety of his own conduct. Undoubtedly, interpretation of these principles by an appropriate authority will be required at times. As a rule, however, the physician who is capable, honest, decent, courteous, vigilant, and an observer of the Golden Rule and who conducts his affairs in the light of his own conscientious interpretation of these principles will find no difficulty in the discharge of his professional obligations.

#### CHAPTER I

##### GENERAL PRINCIPLES

##### CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

##### THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."\*

† Adopted by the American Medical Association House of Delegates and copyrighted December, 1953.

\* Sir Thomas Watson.

#### GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

#### ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

#### THE RELATIONSHIP OF THE PHYSICIAN TO MEDIA OF PUBLIC INFORMATION

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. On the other hand, it may often happen that the representatives of popular news media are the first to perceive the adaptability of medical



material for presentation to the public. In such a situation the physician may be asked to release to the public some information, exhibit, drawing or photograph. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation.

An ethical physician may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published, and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies. Spokesmen should be empowered to give prompt and authoritative replies and a list should be issued which identifies them and discloses the manner in which they may be reached. These provisions are made with full knowledge that the primary responsibility of the physician is the welfare of his patient, but proper observation of these ethical provisions by the physician concerned should protect him from any charge of self-aggrandizement.

Scientific articles written concerning hospitals, clinics or laboratories which portray clinical facts and technics and which display appropriate illustrations may well have the commendable effect of inspiring public confidence in the procedure described. Articles should be prepared authoritatively and should utilize information supplied by the physician or physicians in charge with the sanction of appropriate associates.

When any sort of medical information is released to the public, the promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

#### PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

#### EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

\* Nicon, father of Galen.

## CHAPTER II

### DUTIES OF PHYSICIANS TO THEIR PATIENTS STANDARDS, USEFULNESS, NONSECTARIANISM

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."\* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

#### PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

#### PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

#### THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

## CHAPTER III

### DUTIES OF PHYSICIANS TO THE PROFESSION AT LARGE

#### UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

#### MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.



## SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

## EXPOSURE OF UNETHICAL CONDUCT

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

## CHAPTER IV

## PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER TO EACH OTHER

## DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

## COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

## ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

## CHAPTER V

## DUTIES OF PHYSICIANS IN CONSULTATIONS CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

## CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

## PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

## PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and

the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

## DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made, nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

## RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

## CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

## CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

## CHAPTER VI

## DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

## MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

## SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

## SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

## CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the con-

fidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

#### EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

#### PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

#### A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

#### SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

#### DISPUTES BETWEEN PHYSICIANS

SECTION 9.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

### CHAPTER VII

#### COMPENSATION

##### LIMITS OF GRATUITOUS SERVICE

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

##### CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

##### CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement be-

tween a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

#### FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

#### COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

#### PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

### CHAPTER VIII

#### DUTIES OF PHYSICIANS TO THE PUBLIC PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

##### PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

##### PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

## INDIANA DELEGATION IN CONGRESS\*

## UNITED STATES SENATORS\*

Senior Senator—Hon. Homer E. Capehart.  
(R) Washington, Indiana.

Junior Senator—Hon. William E. Jenner.  
(R) Bedford, Indiana.

\* Address them at Senate Office Building,  
Washington, D. C.

## UNITED STATES REPRESENTATIVES†

First District—Hon. Ray J. Madden.  
(D) 578 Broadway, Gary.

Second District—Hon. Charles A. Halleck.  
(R) Rensselaer.

Third District—Hon. Shepard J. Crumpacker.  
(R) 1906 Bergan St., South Bend.

Fourth District—Hon. E. Ross Adair.  
(R) 925 Lincoln Tower, Fort Wayne.

Fifth District—Hon. John V. Beamer.  
(R) 413 N. Miami St., Wabash.

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(R) Fifth and Liberty Sts., Covington.

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(R) Martinsville.

Eighth District—Hon. D. Bailey Merrill.  
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(R) Bedford.

Tenth District—Hon. Ralph Harvey.  
(R) R. R. 4, New Castle.

Eleventh District—Hon. Charles B. Brownson.  
(R) 119 S. Meridian St., Indianapolis.

† Address them at House Office Building,  
Washington, D. C.

## ELECTED STATE OFFICIALS\*

Office	Incumbent	Politics	Room Number
Governor	George N. Craig	R	206
Lieutenant Governor	Harold W. Handley	R	331
Secretary of State	Crawford F. Parker	R	201
Treasurer of State	John Peters	R	242
Auditor of State	Frank T. Millis	R	238
Attorney General	Edwin K. Steers	R	219
Supt. of Public Instruction	Wilbur Young	R	227
Clerk of Supreme Court	Thomas C. Williams	R	217
Reporter of Supreme Court	Virginia B. Caylor	R	416

\*Incumbents on July 1, 1954.

## DEATHS OF INDIANA PHYSICIANS IN 1953

(Compiled by James B. Maple, M.D., Chairman of Committee on Necrology)  
(M) Member I.S.M.A.; (S) Senior Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death
Rayl, Claudius C. (M)	71	Jan. 3	Decatur	Cerebral hemorrhage
Peters, Robert J. D. (M)	64	Jan. 7	Indianapolis	Myocardial failure, chronic pulmonary emphysema
Allhands, Frank D.	83	Jan. 7	Crawfordsville	Cerebral hemorrhage, arteriosclerosis
McKee, Charles E. (R) (S)	85	Jan. 10	Dublin	Diabetes mellitus, arteriosclerosis
Egbert, Roy (M)	70	Jan. 17	Indianapolis	Heart disease with congestive failure
Young, Edward M. (R) (M)	83	Jan. 17	Sheridan	Intestinal obstruction, carcinoma caecum
Furniss, Sumner A. (R) (M)	78	Jan. 18	Indianapolis	Fracture hip, hypostatic pneumonia, cerebral thrombosis, arteriosclerosis
Glenn, LaFayette (M)	76	Jan. 19	Ramsey	Coronary thrombosis, coronary sclerosis
Kelly, Jon N. (M)	76	Jan. 20	LaPorte	Nephritis, myocarditis, arteriosclerosis
Clark, Cyrus J. (M)	52	Jan. 22	Indianapolis	Auto accident
Bahr, Max A. (R) (M)	78	Jan. 24	Indianapolis	Coronary occlusion, coronary arteriosclerosis



Name	Age	Date of Death		Address	Cause of Death
Gordon, Joshua M.	75	Jan.	25	South Bend	Metastatic carcinoma of the lungs, primary right kidney
Ross, Louis F. (M)	72	Jan.	29	Richmond	Arteriosclerotic heart disease, essential hypertension
Jacobs, Harry A. (M)	72	Feb.	2	Indianapolis	Coronary heart disease, congestive heart failure
Robison, Claude A. (M)	60	Feb.	2	Frankfort	Cerebral thrombosis
Ploughe, Monroe L. (M) (R)	88	Feb.	7	Elwood	Cerebral hemorrhage, hypertrophy of the prostate
Pfaff, John A. (M)	82	Feb.	7	Indianapolis	Coronary heart disease, hypertension
Waller, William F. (R) (M)	71	Feb.	9	Angola	Pneumonia
Collier, Susan E.	92	Feb.	15	Indianapolis	Cerebral thrombosis, arteriosclerosis
Silvers, James M. (M)	80	Feb.	18	Muncie	Hemorrhage right lenticulostrate artery
Cullipher, J. Edward (S) (R)	79	Feb.	20	Elwood	Intestinal obstruction, cholelithiasis
Crockett, Horace E. (R)	76	Feb.	27	Indianapolis	Gastrointestinal hemorrhage
Eshleman, Lindley H. (S)	82	Feb.	28	Marion	Congestive heart failure, postoperative peritonitis, gastric ulcer
Underwood, Charles (R)	75	Feb.	28	Indianapolis	Acute pulmonary failure, arteriosclerotic heart disease, rectal carcinoma
Wilson, Russell C. (M)	58	Feb.	28	Franklin	Acute coronary occlusion
Coffin, Guy R.	78	Mar.	5	Monticello	Paralysis agitans, arteriosclerotic heart disease
Herring, Arthur F. C.	77	Mar.	6	Lafayette	Pulmonary tuberculosis
Carpenter, Thomas B. (M)	32	Mar.	7	Columbus	Cerebral hemorrhage
Tucker, Jesse E.	83	Mar.	10	Elizaville	Uremia, chronic nephritis, arteriosclerosis
Sink, Frank G. (M)	43	Mar.	10	Remington	Cirrhosis of the liver
Schick, Martin F. (R)	91	Mar.	10	Ft. Wayne	Arteriosclerotic heart disease
Cox, Harold B. (R)	68	Mar.	18	Indianapolis	Cardiac dilatation, coronary arteriosclerosis
Baumgartner, Albert J. (R)	85	Mar.	25	Elkhart	Coronary vascular disease
Cox, Joseph B. (R)	74	Mar.	27	Evansville	Coronary occlusion
Runyon, Chandler P. (R)	80	Mar.	28	Elwood	Cerebral hemorrhage
Smith, Waldo E. (M)	81	Mar.	28	Decatur	Cerebral hemorrhage
Petronella, Samuel J. (M)	44	Apr.	1	East Chicago	Coronary occlusion
Estlick, Richard E. (M)	42	Apr.	6	Ft. Wayne	Infectious hepatitis
Perrin, Deckard L.	83	Apr.	6	Seymour	Cerebral arteriosclerosis
Cotton, Stanley M. (M) (R)	75	Apr.	9	Goldsmith	Cerebral hemorrhage, arteriosclerosis
Smith, Waldo E.	81	Apr.	9	Decatur	Cerebral hemorrhage
Huff, Asher D. (M)	55	Apr.	18	Marion	Coronary occlusion
Dailey, John E. (M)	59	Apr.	20	Indianapolis	Coronary occlusion, arteriosclerotic heart disease
Hoover, James J. (M)	70	Apr.	21	Terre Haute	Coronary insufficiency
Hoffman, Curtis R. (M)	58	Apr.	22	Richmond	Myocardial infarction, coronary arteriosclerosis
Mozingo, Arvine E. (M)	71	Apr.	24	Indianapolis	Retroperitoneal hematoma and anuria, arteriosclerotic heart disease
Holmes, Will W. (M)	64	Apr.	28	Logansport	Myocardial infarction, coronary occlusion
Wagoner, Robert H. (M) (R)	79	Apr.	29	Colburn	Coronary occlusion, arteriosclerotic heart disease
Rice, Thompson R. (S)	89	May	9	Petersburg	Intestinal obstruction, arteriosclerotic heart disease
Storch, Lewis A. E. (S) (R)	84	May	11	Indianapolis	Cerebral hemorrhage, chronic myocarditis
Martin, Frank D. (M)	62	May	18	Bedford	Chronic myocarditis, myocardial degeneration
Rifle, Raymond E.	66	May	24	Indianapolis	Coronary occlusion, diabetes mellitus
Kratzer, Eugene F.	76	June	1	Kokomo	Bronchogenic carcinoma
Powell, John F.	78	June	5	Greentown	Coronary heart disease
Higbee, Frank O.	83	June	5	Gary	Chronic myocarditis
Nelson, Richard B.	44	June	9	Hammond	Acute coronary thrombosis, posterior myocardial infarction
Jones, Daniel D. (S) (R)	82	June	11	Berne	Cerebral thrombosis, arteriosclerosis
Beckes, Norman E. (S)	80	June	19	Vincennes	Pleurisy with effusion, pneumonitis
Briggs, Carl F. (M)	72	June	20	Sullivan	Coronary thrombosis
Thompson, Noah H. (S) (R)	83	June	29	Wabash	Myocardial failure

Name	Age	Date of Death		Address	Cause of Death
Bennett, Pearl R.	75	July	4	Terre Haute	Senile dementia
Shafer, John W. (S) (R)	80	July	10	Lafayette	Coronary thrombosis
Fisk, Frank B. (M) (R)	64	July	10	Indianapolis	Coronary thrombosis
Yocum, Boaz (S) (R)	85	July	17	Coal City	Adenoma of the prostate
Stuckman, Edwin D. (S)	84	July	18	New Paris	Carcinoma of the lower esophagus
Alexander, Harry H. (M)	74	July	29	Princeton	Carcinoma of the prostate
Brenner, Ivan E. (M)	63	Aug.	4	Winchester	Uremia and malignant hypertension
Zimmerman, Amelia	84	Aug.	8	LaPorte	Arteriosclerosis, hypertension
Lindt, Harriet L.	76	Aug.	10	South Bend	Metastatic pulmonary sarcoma
Robertson, Moorman O. (M)	66	Aug.	18	Bedford	Auto accident
Teaford, Schuyler S. (S)	80	Aug.	23	Paoli	Carcinoma of the colon
Engle, John M.	37	Sept.	3	Portland	Coronary occlusion
Austin, Fred H.	83	Sept.	4	Bloomington	Retrocecal abscess, ruptured appendix
French, William G.	68	Sept.	11	Evansville	Coronary thrombosis
Rodenbeck, Frank (M)	71	Sept.	17	Arcadia	Dissecting aneurysm of the aorta
Cayley, Frank J.	65	Sept.	18	Indianapolis	Angina pectoris
Ikins, Ray G. (M)	56	Sept.	28	Lafayette	Carcinoma of the mediastinum
Patton, Benjamin F.	86	Sept.	28	Terre Haute	Generalized arteriosclerosis and cerebral thrombosis
Eberhart, James D. (R)	82	Oct.	6	Shelbyville, R. R.	Carcinoma of the sigmoid
Catlett, Marshall B. (M)	65	Oct.	7	Ft. Wayne	Arteriosclerotic heart disease
Swayne, Jap F. (M)	66	Oct.	7	Indianapolis	Acute anterior myocardial infarction and coronary sclerosis
Rhodes, Amos H. (S)	75	Oct.	15	Princeton	Coronary thrombosis
Jones, Frank C.	90	Oct.	17	Frankfort	Intestinal obstruction
Johnson, Earl E. (M)	68	Nov.	4	Covington	Arteriosclerotic heart disease
Delph, John F.	59	Nov.	7	Michigan City	Coronary heart disease, pulmonary thrombosis, infarction
Saunders, Jones L. (M)	37	Nov.	12	Newport	Coronary thrombosis, coronary sclerosis
Cuthbert, Frederick S. (M) (R)	77	Nov.	20	Kokomo	Coronary thrombosis
Funkhouser, Arthur G. (M)	59	Nov.	21	Indianapolis	Glioblastoma multiforme of brain
Kent, John A. (S)	80	Dec.	1	Mulberry	Chronic pyelonephritis
Reed, Jewett V. (M)	75	Dec.	4	Indianapolis	Pneumonia
Smith, Robert A. (M)	51	Dec.	7	New Castle	Myocardial infarction, coronary thrombosis
Stoler, Albert E. (M)	73	Dec.	16	Ft. Wayne	Cardiovascular renal disease
Pierson, Percy R. (M)	65	Dec.	29	New Albany	Carcinoma of the lungs

## CLEARVIEW

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## THE MONTH IN WASHINGTON

WASHINGTON, D. C.—The controversial health reinsurance issue has come back into prominence, and under conditions that make the whole question about as complicated as it can get. The bill would have the federal government underwrite voluntary health insurance plans if they agree to experiment with risks not usually covered.

Although this measure is a major part of President Eisenhower's health program, it became bogged down in the House Interstate and Foreign Commerce Committee when widespread opposition developed. Then the committee chairman, Rep. Charles E. Wolverton (R.-N.J.), turned to one of his favorite subjects, a plan for federal guarantee of private loans to health

facilities for construction and equipment. This bill, however, was not supported by the administration.

In an effort to placate the opposition, Mr. Wolverton offered to eliminate a number of objectionable features from the mortgage guarantee bill. At the same time there were reports that he proposed to merge this bill with the administration-supported reinsurance bill. Meanwhile, Henry J. Kaiser made two special trips to Washington to help out his friend, Mr. Wolverton, by putting his weight behind the mortgage loan idea. That was not surprising, inasmuch as Mr. Kaiser had helped to draw up the bill, which would greatly benefit health centers

(Continued on page 769)

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## The Month in Washington

(Continued from page 768)

such as those started on the West Coast by the Kaiser Foundation.

Mr. Kaiser, saying he was producing a film to promote the mortgage loan plan, went to the unusual extent of making a direct appeal to Washington news correspondents to write favorable copy about the bill.

While these Wolverton-Kaiser maneuverings were taking place on the mortgage bill, it became apparent that President Eisenhower was not ready to abandon the reinsurance idea. He called a number of executives of major life insurance companies to the White House to try to impress them with the merits of reinsurance and in other ways indicated he still wanted to see the bill passed this session. Secretary Hobby, whose original testimony for reinsurance had been restrained, also joined in the last-minute campaign. But it appeared the tangle might be too complicated even for Mr. Eisenhower to unravel before adjournment.

Most other parts of the Eisenhower health program were moving through Congress, even though some were off schedule. (Of the major bills, AMA opposes only reinsurance.) Legislation to expand the Hill-Burton hospital construction program cleared what might have been a serious obstacle when it was reported out by the Senate committee. Compared with the House bill, the Senate bill gave more discretion to state health authorities in use of funds for constructing facilities for the chronically ill, for nursing homes, and for health centers. However, the Senate would require that funds earmarked for rehabilitation centers be used for the stated purpose. The Senate also would rule out the possibility of U. S. grants to centers

devoted solely to treatment. Unless the facility could qualify as a diagnostic center, or a diagnostic-treatment center, it could not be eligible under the Senate bill. This safeguard was not in the House bill.

Of the remaining legislation of interest to the medical profession, the status at this writing was about as follows:

The doctor draft amendment, to strengthen Defense Department's hand in dealing with phy-

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sicians who might be security risks, had passed the Senate, been reported by the House committee, and was almost a law. Also about to be enacted was a provision liberalizing medical expense deductions from taxable income. The long-dormant bill to transfer responsibility for Indians' health matters from the Indian Bureau in Interior Department to Public Health Service in the Department of Health, Education, and Welfare was pointed toward enactment, but might possibly be held up by objections of Senators from a few western states. The Interior Department had dropped its original objection.

The House-passed social security bill, with the compulsory coverage of physicians elimin-

ated, was before the Senate Finance Committee, where anything could happen. Two bills of medical interest already had been passed by both houses and signed into law. One prohibits the shipment of fireworks into a state where fireworks are illegal, and the other relieves Army medical officers of the technical responsibility for supervising preparation of food.

A reassuring note was sounded by President Eisenhower when he forwarded to Congress the controversial International Labor Organization convention on minimum standards of social security with a recommendation that it not be ratified. His message said most of the points—including a suggestion for socialized medicine—were not proper subjects for the Congress to deal with.

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# The President's Page

FELLOW MEMBERS OF I. S. M. A.:

AS I SAT watching television the other night I was surprised to see Senator Dirksen come on and start talking for the Federal Reinsurance bill. This is the bill that would appropriate \$25,000,000 to set up a fund to reinsure insurance companies writing health and hospital insurance. The purpose is to stimulate the extension of these services to a wider group of people, or larger payments to our own insured groups.

The catch in the bill is that you are charged 2 percent of your total income for being insured and only receive back 75 percent of your losses. The insurance does not apply until you have paid out the amount usually allowed for both claims and overhead. If you wrote any volume of this type coverage any company would go broke in a short time. The reinsurance plan will not reach the people that are not now covered under the present program—the aged, the chronically ill and medical indigents.

At the meeting in New York Blue Shield Plans in the United States voted against participation. At the hearings in Washington all of the old line carriers testified it was not practical.

This bill may be voted upon before this is published but I wanted you to know something of why our own Blue Shield was against it.

You know by this time that social security for physicians was defeated in committee. It was called up under a rule that did not allow any amendments on the floor. The first vote of the House Ways and Means Committee was 12 to 8 to include physicians in social security. The A.M.A. testified before this committee against the inclusion of physicians. They were told that it was the committee's idea that they did not truly represent the thinking of the doctors of the U.S.A. This word was sent back to all the state medical associations and they were asked to get busy. The county societies were notified and asked to write or wire the House Ways and Means Committee. The flood of telegrams that poured in must have had its effect as the committee reversed itself and voted 12 to 8 to exclude physicians. At the same time it left all the other professional groups covered.

It has been said many times that the doctors of this country have much more influence than they often feel that they have. We have a powerful organization and as long as we use it for the public good there can be little criticism of our actions.

The State Association's public relations program will not get under way until September. By the time it was gotten into shape the summer was here and the committee felt we would get much better radio and television coverage in the fall and winter months.

The Blue Shield Board is considering paying \$10 for the first day medical coverage in all its contracts with no increase in cost to the subscriber. This has already been passed by the Executive Committee.

*Wm Harry Howard M.D*



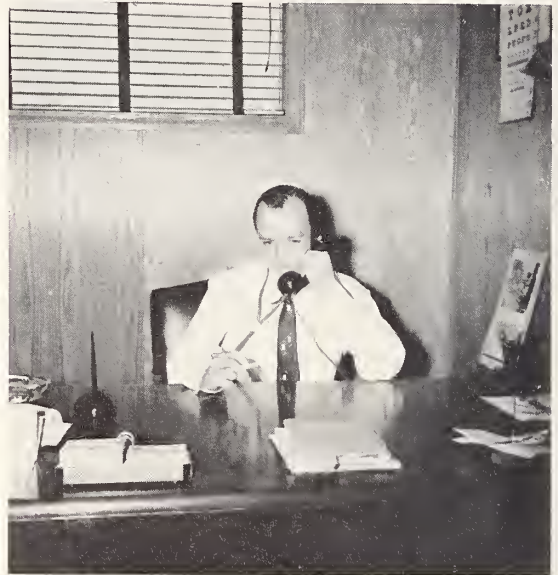
## RURAL PRACTICE AND GENEROUS COMMUNITY ATTRACT YOUNG PHYSICIAN

William Paynter, graduate of Indiana University School of Medicine in the class of 1952, is now a full-fledged physician with a round-the-clock practice in the small town of Pekin in Washington County.

Doctor Paynter, who is a native of Salem, completed his internship at a Lafayette hospital July 15, 1953 and a few weeks later returned to his home county to establish practice in a new, thoroughly modern office building which the citizens of the community helped provide as a means of attracting a young doctor to the town. A loan fund of \$15,000 was raised through the Pekin Grange and the balance Doctor Paynter financed personally.

In the town of 650 population, the young doctor serves the entire community and some surrounding territory as well. Established less than a year, he works from early morning until midnight or 1 o'clock each day with the exception of Thursday. That's his day off, but it seldom begins before 4 in the afternoon and after that he generally sandwiches in a few house calls. Sunday mornings are extremely busy and afternoon and evening a repetition of Thursdays.

"If I was any busier I'd have to have an

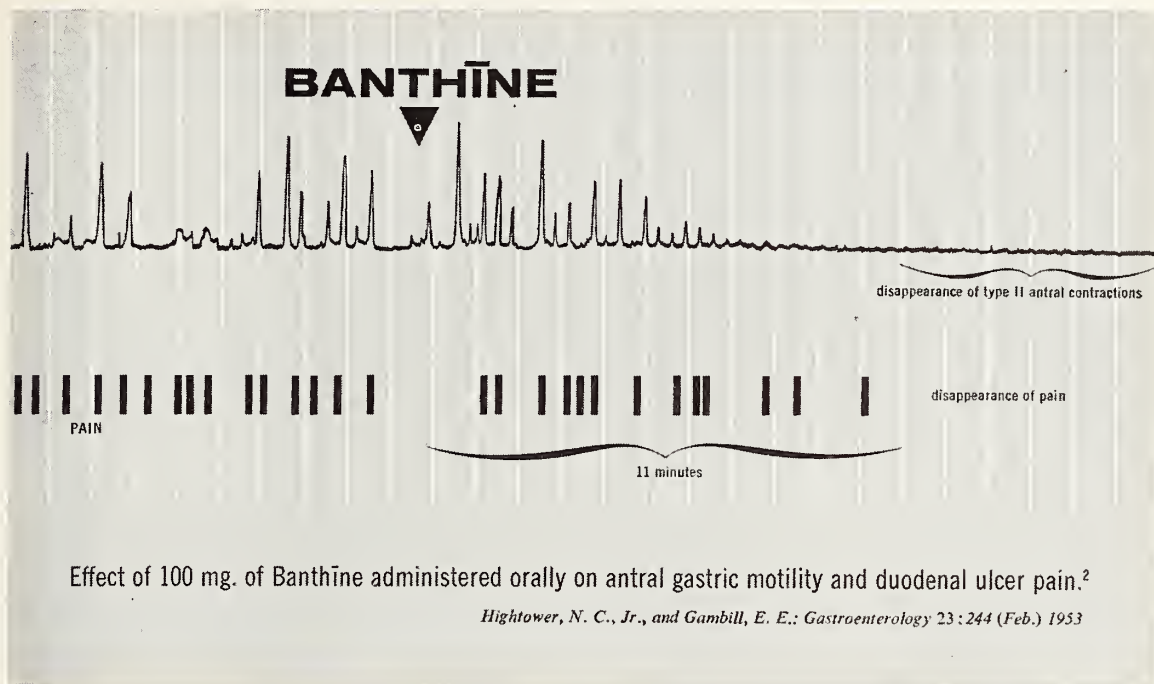


At a desk cleared for photographic reasons, Dr. William Paynter, Pekin, answers a routine telephone call from a patient. His new office building is pictured below.

eighth day in the week," Doctor Paynter told THE JOURNAL in a grateful tone.

His modern redwood and limestone office building has three examining rooms, drug, consultation and waiting rooms and a carport. Doctor Paynter is married. He maintains his office with the assistance of a registered nurse.





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Ruffin, J. M.; Texer, E. C., Jr.; Carter, D. D., and Baylin, G. J.: *J.A.M.A.* 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

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# Deaths . . .

**Alonzo Clark Newby, M.D.**, 75, who had practiced medicine in Hamilton county for almost 52 years, died May 9 in his Sheridan home after a long illness. He was a native of Sheridan where his father, Dr. John C. Newby, practiced medicine for many years. Doctor Newby was a graduate of the Medical College of Indiana in 1903 and spent his entire professional career in Sheridan. In addition to his private practice he was physician and surgeon for the Monon Railroad.

Doctor Newby was a member of the Hamilton County Medical Society, a senior member and Fifty Year Club member of the Indiana State Medical Association and was also a member of American Medical Association. He was also a 50-year member of the Masonic lodge.

Among survivors is his son, Eugene Newby, M.D., who assumed his father's practice when illness forced him to retire.

**Wilbur Curtiss Mathews, M.D.**, 68, died in a Watseka, Illinois hospital on May 11. Doctor Mathews, who had practiced in Kentland for 43 years made an early morning call May 11, returned to his Kentland home about 7 o'clock and suffered a heart attack. He was taken to the Watseka hospital where he died a few hours later.

Doctor Mathews was a graduate of the University of Louisville School of Medicine in 1911. He was a member of the Jasper-Newton County Medical Society, the Indiana State and American Medical Associations.

**Shirley Lang, M.D.**, 73, died in Deaconess Hospital, Evansville, May 10 after a month's illness. He suffered a heart attack while in Florida and was brought to the Evansville hospital. He had been in practice in Evansville for 30 years prior to his retirement in 1952.

Doctor Lang received his medical degree from the University of Illinois College of

Medicine in Chicago in 1905 and immediately established his practice in Rockport where he remained until 1922. He was a member of Vanderburgh County Medical Society, the Indiana State and American Medical Associations.

A month after being stricken with a heart attack while driving to his parents' home in Cleveland, **Robert M. McMichael, M.D.**, Muncie obstetrician and gynecologist, died in Lakeside Hospital, Cleveland. Doctor McMichael's death occurred on May 19. He was 48 years old. Doctor McMichael received his medical degree from Western Reserve University School of Medicine, Cleveland, in 1931. He interned at Cleveland City and Lakeside Hospitals before coming to Muncie in 1935. During World War II Doctor McMichael served 40 months in the U. S. Navy and was discharged with the rank of lieutenant-commander. He was a member of Ball Memorial Hospital staff and belonged to the Muncie Academy of Medicine, Delaware-Blackford County Medical Society, the Indiana State and American Medical Associations.

**George C. Jacobs, M.D.**, 74, who had been in limited practice in Kentland for the last two years, died in St. Elizabeth's Hospital, Lafayette, May 13. He had been ill for three weeks. Doctor Jacobs was a graduate of Chicago College of Medicine and Surgery in 1908. He was a prominent physician and surgeon in Fergus Falls, Minnesota, for many years. He was a member of the Jasper-Newton County Medical Society, the Indiana State and American Medical Associations.

**Karl R. Hefti, M. D.**, 48 year old Evansville surgeon, died May 28 apparently while attempting to reach a supply of oxygen he kept in his bedroom because of a severe bronchial asthma condition for which he had been under



treatment for several years. He was preparing to leave for Chicago within a few days to begin new treatments.

Doctor Hefti was a native of Chicago where he received his medical degree in 1938 from Northwestern University Medical School. He interned at the Medical Center in Jersey City, New Jersey, and practiced there before coming to Evansville in 1943. He was plant physician at International Harvester works in Evansville and had served in the same capacity for two other industries which he had discontinued because of his health. He was on the staffs of Welborn Baptist, St. Mary's and Deaconess Hospitals, and was a member of Vanderburgh County Medical Society, the American College of Surgeons, the Indiana State and American Medical Associations.

For the last 10 years Doctor Hefti had maintained offices with his wife, Jane M. Hoopes, M.D., a pediatrician.

hemorrhage in his Huntingburg home. He had been in ill health for two years. Doctor Bretz was a native of Jasper. He received his degree in medicine in 1909 from Western Reserve University School of Medicine, Cleveland. In 1911 he began the practice of medicine in Memphis and in 1917 went to Huntingburg where he had practiced since. During World War I he served as a first lieutenant in the Army Medical Corps. He was the first chairman of the Dubois County Selective Service Board during World War II and retained that post until 1952. He had served for more than 20 years as Dubois county health officer.

Doctor Bretz was a member of Dubois County Medical Society which he served for four years as secretary. He was also a member of the Indiana State and American Medical Associations. His son, John M. Bretz, M.D., is in practice in Huntingburg.

W. Daniel Bretz, M.D., 70, died May 21 a few hours after he had suffered a cerebral

Hamilton M. Arthur, M.D., practicing physician in the Hazelton community for 53 years, died June 1 in the Gibson General hospital,

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Princeton, where he had been taken two days earlier after fracturing a hip in a fall at his home. He was 81 years old and had been prominent in his profession and in civic affairs for many years.

A native of Daviess county, he was graduated from the Medical College of Indiana at Indianapolis in 1898. He practiced first in Alfordsville, then went to Hazelton in 1901. His life there was closely linked to the small community. He had delivered 1,900 babies and had severed several generations of a number of families. For many years his practice took him throughout Gibson, Knox and Pike counties. He had served as president of the Hazelton State and Gibson County banks since 1912 and was active over a long span of years in lodge work. He was a 50 year member of the Masonic lodge, the I.O.O.F., and the Rebekah lodge and had belonged to the Eastern Star for 49 years.

His long service in the medical profession had been recognized officially by the Indiana State Medical Association of which he was a Fifty Year Club and senior member. The town of Hazleton celebrated his 50 years of

practice in 1951 with a community celebration. He was a member of the Gibson County Medical Society and the American Medical Association.

Among his survivors is N. Maude Arthur, M.D., Washington, a sister.

**Ralph P. Townsend, M.D.**, Michigan City, died suddenly May 24. He was 39 years old. Doctor Townsend received his medical degree from Cornell University Medical College, New York, in 1942. He served internship and residencies at Illinois Research Hospital and the Bronx Veterans Hospital. Doctor Townsend was a psychiatrist and had been licensed in Indiana since 1952. He was a member of LaPorte County Medical Society and the Indiana State Medical Association.

**Clarence W. Mulliken, M.D.**, 73, who retired in 1952 after practicing several years in Greensburg, died April 29 in Tucson, Arizona, where he was living. He had been ill only a short time. Doctor Mulliken was a 1908 graduate of Indiana University School of Medicine and began his career on an In-

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dian reservation near Tucson. A year later, in 1909, he went to Ridgeville where he was in practice for several years before going to Greensburg.

---

**Gerald Williams Gustafson, M.D.**, Indianapolis obstetrician and gynecologist and professor of those subjects at Indiana University School of Medicine, died May 14 in Massachusetts General Hospital, Boston, where he had been a surgical patient for several weeks. He was 54 years old.

Doctor Gustafson was considered a national authority on obstetrics and gynecological subjects. He was a frequent speaker at medical specialty group meetings as well as at the American Medical Association conventions. A paper delivered at the Seventh Clinical meeting of A.M.A. last December in St. Louis is published in the June 5 issue of the Journal of the American Medical Association. His last paper in THE JOURNAL of the Indiana State Medical Association appeared in November, 1953.

A native of Chesterton, Doctor Gustafson received his degree in medicine from Northwestern University Medical School, Chicago, in 1925. He interned at Methodist Hospital, Indianapolis, and served a residency at Chicago Lying-In Hospital. Before coming to Indianapolis in 1927 to establish private practice he was an assistant to Dr. E. L. Cornell, Chicago.

Doctor Gustafson held membership in the Indianapolis Medical Society, the Indiana State and American Medical Associations, the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, the Central Association of Obstetricians and Gynecologists, and the American College of Surgeons. He was on the staffs of Coleman, St. Vincent's and Methodist Hospitals.

Doctor Gustafson had served for several years on committees of I.S.M.A. In 1945 he was a member of the advisory committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health and was chairman of that committee in 1946 and 1947. In 1948 he was named chairman of the I.S.M.A. Committee on Maternal and Child Health and was a member of that committee from 1949 through 1953.

**Edwin Mercer Wells, M.D.**, 87, native of Jefferson county, died May 2 in Bellingham, Washington. He received his medical degree from the University of Louisville and practiced for a time in New Washington, Clark county. He served as a captain in the Medical Corps during World War I. Among survivors is his brother, H. O. Wells, M.D., formerly of Fort Wayne, but now a resident of Fort Lauderdale, Florida.

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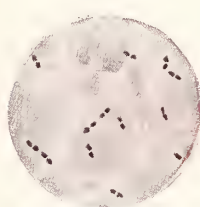
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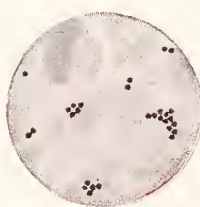
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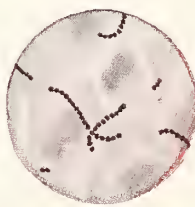
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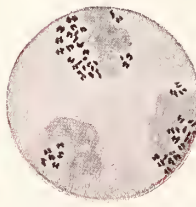
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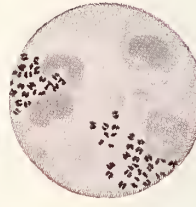
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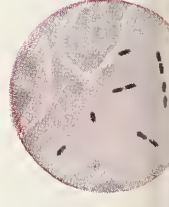
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A recent study points out that patients with peptic ulcer, ulcerative colitis or regional enteritis can effectively utilize good quality protein from animal sources.\* Protein hydrolysates apparently are less effectively utilized than intact protein.

In patients with uncomplicated peptic ulcer on regimens providing intact animal proteins the patterns of amino acid excretion in urine and feces were similar to those in normal subjects. In patients with ulcerative colitis or regional enteritis the increased output of nitrogen and amino acids in the feces was attributed to loss of intestinal secretions, inflammatory exudate, and blood. Although the patients utilized intact animal proteins effectively, the authors suggested that an intake of more than one gram of dietary protein per kilogram of body weight might be useful.

On the basis of this study a dietary plan recommended for treatment of gastrointestinal disorders provides at least one gram, of protein per kilogram of body weight, but preferably more. Meat constitutes one of the important sources of animal protein in the plan.

In dietotherapy, meat serves many important physiologic and nutritional functions. Its appetizing flavor animates the desire to eat and promotes good digestion. Meat is easily and almost completely digested. Its high content of protein provides goodly amounts of all the essential amino acids well supplemented with others. Meat also contributes valuable amounts of many B vitamins and of essential minerals, especially iron, phosphorus, and potassium.

\*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, *J. Am. Dietet. A.* 29:1103 (Nov.) 1953.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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# NEWS NOTES — from State and Nation

## Dr. Donald J. Caseley Joins U. of Illinois Staff

The University of Illinois has announced the appointment of Dr. Donald J. Caseley, former medical director of the Indiana University Medical Center, to be medical director of its research and educational hospitals and associate dean of its College of Medicine in Chicago.

Since leaving the I. U. Medical Center in 1952 Dr. Caseley has been medical director of St. Luke's Hospital, Chicago. He is a graduate of DePauw University, received his medical degree from Indiana University School of Medicine and served six years as a member of its administrative staff and faculty.

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Dr. John P. McNamara, who has been on the staff at Norways, has left for Topeka, Kansas, where he will begin a five year psychiatric training program at the Menninger School of Psychiatry.

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The 31st Convention of the **National Society for Crippled Children and Adults** will be held in the Hotel Statler, Boston, November 3 through November 5.

Dr. H. Cleve Ashmore, who has been practicing in Hebron for the last two years, joined Dr. Joseph P. Griffin, Chesterton, in practice June 1. Dr. Griffin announced that they will be associated in the general practice of medicine and surgery and will stagger office hours to see patients over a longer period of time daily.

Dr. Ashmore, a native of Greensboro, North Carolina, received his degree in medicine from Indiana University School of Medicine in 1951. He completed a years' internship at Gary Methodist hospital before establishing his practice in Hebron. He is a navy veteran having served from 1941 through 1945 when he was released with the rank of lieutenant-commander.

---

Dr. Norval Rich has purchased the Dr. John Terveer property on Madison street, Decatur, and will open an office for the general practice of medicine there during July. Doctor Rich formerly lived in Berne, is a graduate of Indiana University School of Medicine and is completing his internship at Mercy Hospital, Springfield, Ohio. He is a World War II veteran, is married and has four children.

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**4** Hypotensive action is independent of alterations in heart rate.

**5** Cardiac output is not reduced.

**6** Renal function, unless previously grossly reduced, is not compromised.

**7** Cerebral blood flow is not decreased.

**8** Cardiac work is not increased, tachycardia is not engendered.

**9** No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily over-

come and thereafter avoided by dosage adjustment.

**10** In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.

**11** Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

**12** Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

**13** Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

**14** A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

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## Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), the toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety.<sup>3</sup> If excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.

2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.

3. Stearns, N. S. and Ellis, L. B.: Acute Effects of

Intravenous Administration of a Preparation of *Veratrum Viride* in Patients with Severe Forms of Hypertensive Disease, *New England J. Med.* 246:397 (Mar. 13) 1952.

4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, *Am. J. M. Sc.* 226:477 (Nov.) 1953.

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### Membership of the N.G.A. Transferred to College

Membership of the National Gastroenterological Association, classified as to present status, was recently transferred by vote to the newly activated American College of Gastroenterology at a special meeting in New York City. The transfer included all assets including the official publication, The American Journal of Gastroenterology.

The College will hold its first convention on October 25, 26 and 27 in Washington, D.C.

Eighty-five physicians, dentists and pharmacists attended the 31st annual convention of the **Indiana State Medical, Dental and Pharmaceutical Association** held in Gary recently. Gary has been host to the group for the last three years. Separate sessions of the three affiliated groups were held during the two day session. Dr. G. Kenneth Washington opened the meeting and Dr. D. W. Turner, oldest member of the Gary chapter, introduced the principal speaker, Simcha Pratt, Chicago counsel for the State of Israel. Toastmaster for the annual dinner was Dr. Benjamin F. Grant.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its **Annual Assembly in Otolaryngology** from September 6 to 11. Dr. Maurice F. Snitman will have charge of the assembly which will be devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat.

Registration will be limited. Information may be obtained from the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Indianapolis doctors who attended sessions of the American Psychiatric Association's annual meeting in St. Louis early in May were Drs. Philip Reed, Arthur Blair and Richard Greenbank.



### Occupational Therapists To Meet in Washington

The 37th Annual Conference of the American Occupational Therapy Association will be held in the Shoreham Hotel, Washington, D. C., October 16-22.

Preliminary meetings are scheduled for October 16 and 17; an institute on interpersonal relations on October 18-19 and the general conference on October 20-22. Theme of the conference will be "Capitalize Your Assets."

Under the auspices of the **American College of Physicians** a course in "Newer Developments in Cardiovascular Diseases" will be given at Mount Sinai Hospital, New York, October 11 through 15. Dr. Arthur M. Master and Dr. Charles E. Friedberg will direct the course and prominent cardiologists and cardiac surgeons will participate. Information may be obtained from Dr. Arthur M. Master, Mount Sinai Hospital, Fifth Avenue and One-Hundredth Street, New York 29, New York.

Dr. Lloyd Hill, who completed his internship in June at General Hospital, Indianapolis, established an office for the general practice of medicine in Denver, Miami county, July 1. The Denver Community Association, which had been seeking a doctor for a year, made arrangements for office quarters and is seeking a suitable home for the new doctor and Mrs. Hill.

Dr. Howard W. Mitchell, Terre Haute, an Indiana University Medical School graduate in 1949, is undergoing a program of orientation at the Indiana State Board of Health during the summer. He will enter the University of Michigan for postgraduate work in public health in the fall. Doctor Mitchell, whose home is in Terre Haute, recently returned after spending two years in Iran in the U. S. Public Health Service.

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## St. Louis Diabetes Summer Camp to Open August 16

Camp Lions Den 12 miles south of St. Louis on U. S. Route 21, a summer camp for diabetic children, will be open from August 16 to September 5. Applications are now being received. Forms may be obtained by writing to the St. Louis Diabetes Association, 3839 Lindell, St. Louis 8, Missouri. Deadline for applications is July 31.

The camp, a part of the Boy Scout Camp, is located on 250 acres of rolling wooded land. There are cottages, a large dining hall, a small hospital and a swimming pool. A program of outdoor activities under close supervision has been planned. Camp Lions Den, which is sponsored by the St. Louis Diabetic Association and backed by the Lions Council of Greater St. Louis, is amply staffed.

Dr. John V. Thompson, Indianapolis, recently presented several cases to the Association for Thoracic Surgery at Montreal, Quebec. His paper was entitled "Plastic Reconstruction of the Trachea and Bronchii."

Dr. Emor L. Cartwright, Fort Wayne, has returned from Europe where he attended meetings of the American College of Surgeons which were held at the University of Leeds, England, in London, Paris, and other European cities. He was accompanied by Mrs. Cartwright.

Dr. Steve Bowen, who formerly practiced at Norton, Virginia, recently established offices in the new Doctors' Office building in Crane Village where he will serve as physician and surgeon for the community.

Dr. Vincent G. Canganelli, who was graduated from Indiana University School of Medicine in 1952, has returned to Indianapolis, to complete further resident training at Norways. Doctor Canganelli, interned at St. Vincent's Hospital, Indianapolis, and has been in psychiatric resident training at Hastings State Hospital, Ingelside, Nebraska.



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An annual cash prize and certificate of merit will be presented at the 1955 convention of the **International Academy of Proctology** for the best unpublished contribution on proctology or allied subjects. The \$100 prize contest is open to all physicians. Entries should be limited to 5,000 words, must be typewritten, five copies submitted and must be received by February 1, 1955. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

Announcement has been made by **Drs. C. R. Buikstra, John C. Cacia and John E. Alexander** that **Dr. Joseph J. Guckien** has joined them in practice in the Hulman Building, Evansville. He will specialize in otolaryngology. Doctor Guckien is a native of Logansport, received his medical degree from Loyola University in 1948 and interned at Mercy-Loyola Hospital, Chicago. He then spent four years in Milwaukee hospitals in eye, ear, nose and throat residency. He is certified by the American Board of Otolaryngologists. During the last year he has been with the army in Japan and Korea and has just completed his service. Dr. and Mrs. Guckien are living at 761 S. Morton avenue, Evansville.

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**Dr. Tom W. Wachob, Jr.**, who has been in practice at the Southern Clinic, Texarkana, Arkansas, for the last two years, has established an office in Kokomo where he will specialize in gynecology and obstetrics. Doctor Wachob, a native of Illinois, received his M.D. from the University of Illinois in 1946 after which he served a rotating internship at St. Elizabeth's Hospital, Lafayette.

He was a medical officer in the air force and the army for two years, spending most of that time on Guam. Returning to civilian life he had a year's residency at the St. Louis City Hospital and returned to St. Elizabeth's for an additional two years before going to Texarkana. He has established offices at 516 Armstrong-Landon Building, Kokomo. He is married and his residence is at 1319 West Jefferson Street.

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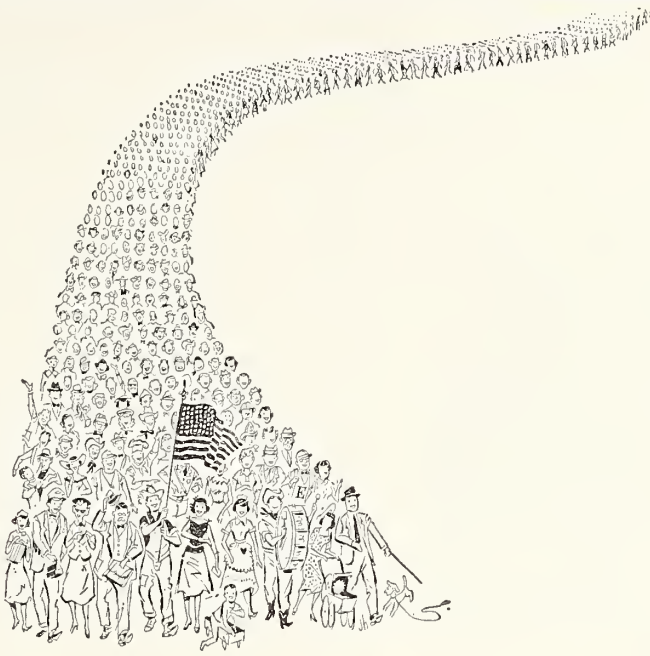
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Dr. Paul W. Elliott, who has been in general practice in Danville for three years began a four year residency in pathology at Indiana University Medical Center July 1. He is a 1950 graduate of Indiana University School of Medicine.

Drs. Earl Bailey and Donald K. Winters have been appointed medical advisors to the Cass County Selective Service board, which now has three members. Dr. Brice E. Fitzgerald has served since the board was reactivated in 1948. Medical advisors eliminate those draft eligible men who are obviously unfit for military service. Cost of sending each registrant to Indianapolis for examination has been estimated at \$50.

Construction is under way on the new office building of Dr. M. S. Mount at the corner of Franklin street and Indiana avenue, Bloomfield. The modern building will be easily accessible from its private parking area.

## THE RETREAT

### ALCOHOLISM AND DRUG ADDICTION



A Private Institution for the Treatment of Alcoholism and Drug Addiction.

*Modern Methods Used*

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Dr. Albert J. Crevello, specialist in neurology and psychiatry, has opened a new office at 26 North 6th Street, Evansville. He will continue his association with Clearview Sanitarium where he has been for the last six years but will also maintain his private office.

Dr. John Van Wienan was recently elected chief of staff at Morgan County Memorial Hospital, Martinsville. Other officers are Dr. James Farr, secretary-treasurer; Dr. Leon Gray, chief surgeon; Dr. E. M. Pitkin, head of medical division and Dr. Van Wienan, head of obstetrics division.

Dr. Louis A. Schneider, associate pathologist at St. Joseph Hospital, Fort Wayne, has resigned as parttime medical director of the Fort Wayne Regional Blood Center. He recently returned from a European vacation. He had served as medical director of the blood center since 1951, when he came to Fort Wayne from New York. A new director is to be named soon subject to the approval of the Fort Wayne Medical Society.

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### New York Academy to Hold Graduate Fortnight

The 27th Annual Graduate Fortnight of the New York Academy of Medicine will be held from October 18 through October 29 at Academy headquarters, 2 East 103 Street, New York. Six morning panel meetings, afternoon hospital clinics, and 21 evening lectures have been planned. Scientific exhibits will also be on display.

Theme of this year's Fortnight will be "Infections and Their Management."

Fees for non-members are \$10.00 for the entire program or \$6.00 for either week. Medical officers in uniform will be admitted without charge.

Requests for programs should be mailed to Secretary, Graduate Fortnight, 2 East 103 Street, New York 29, New York.

**Dr. Frederick H. Evans** has returned to Indianapolis and opened his office at 17½ West 22nd Street, for the general practice of medicine. He has been serving as company commander and regimental surgeon of the 9th Infantry Regiment, 2nd Division. Doctor Evans was awarded the Bronze Star for meritorious service and the Combat Medical badge. He served in Korea.

**Dr. Daniel F. Paul**, Rock Island, Illinois, has established practice in Williamsport where he has offices in the Community Hospital. He will be associated with Dr. James Crain, resident physician and surgeon. Doctor Paul is a graduate of Hahnemann Medical College, Philadelphia, and has been in both private and clinic practice in Delaware. He was asked by the hospital directors to go to Williamsport as the result of community need.

**Dr. Paul M. Dassel**, 1944 I. U. graduate, recently was certified by the American Board of Radiology. He is a native of Evansville, served his internship at St. Margaret Hospital, Hammond, was a captain in the Army Medical Corps, with most of his service in Japan, was in general practice in Hammond and Dyer and then accepted a three year residency in radiology at Veterans Administration Hospital, Hines, Illinois from 1951 to 1954.



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**LOUISVILLE, KENTUCKY**  
Ostertag Optical Service, Inc.  
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Only **audivox** in the hearing aid field can trace an ancestry that includes both Western Electric and Bell Telephone Laboratories. **audivox** lineage springs from the pioneer experiments of Dr. Alexander Graham Bell, which were furthered by the development of the hearing aid at Bell Telephone Laboratories, and in turn, brought to fruition by Western Electric and **audivox** engineers.

Distinctly a thoroughbred in its field, **audivox**, successor to Western Electric Hearing Aid Division, brings the boon of better hearing, and its enrichment of living, to thousands. With the magical modern transistor, with scientific hearing measurement and scientific instrument-fitting, serviced by a nationwide network of professionally-skilled dealers, **audivox** moves forward today in a proud tradition.

**TO THE DOCTOR:** Send your patient with a hearing problem to a career Audivox and Micronic dealer, chosen for his interest, integrity and ability. There is such an Audivox dealer in every major city from coast to coast.



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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

May 23, 1954

Roll call showed the following present: James W. Denny, M.D., chairman; Walter L. Portteus, M.D.; E. H. Clauser, M.D.; Wm. Harry Howard, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Robert Hollowell, attorney; Robert J. Amick,

and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

### Membership Report

Number of members May 22, 1954 . . . . . 3,735\*  
Number of members May 22, 1953 . . . . . 3,640  
Gain over last year . . . . . 95  
Number of members December 31, 1953 . . . . . 3,821

\* Includes

122 in military service (gratis)  
83—\$10.00 members (residents and interns)  
265—senior members  
62—members, dues remitted by Council  
2—honorary members

AMA dues paid: 1952 . . . 3,569; 1953 . . . 3,626\*\*;  
1954 . . . 3,518\*\*.

\*\* Includes 420 members permanently exempted in 1952.

### Headquarters Office

Mr. Amick reported on his activities during the past month, as did Mr. Bush.

The executive secretary discussed the need for additional office space for the headquarters office inasmuch as the recording library was becoming quite a problem and the installation of new equipment which was coming and after discussion, upon motion of Drs. Clarke and Clauser the secretary was authorized to rent additional space up to 495 square feet.

### Treasurer's Office

Dr. Roy V. Myers, treasurer, reminded the committee that \$30,000.00 which had been placed in time certificates had been called and asked permission of the Executive Committee to reinvest the \$30,000.00 in U. S. Savings Bonds, Series K. Per-

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for emotionally disturbed children . . .

## THE ANN ARBOR SCHOOL

. . . is a private school for children from six to fourteen, of average or superior intelligence, with emotional or behavior problems.

. . . providing intensive individual psychotherapy in a residential setting.

A. H. KAMBLY, M. D.  
Director

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Ann Arbor, Michigan



mission was granted on motion of Drs. Portteus and Clarke.

Statements of Receipts and Expenditures for February, March and April for the Association and for April for THE JOURNAL were accepted by consent.

#### Legislative Matters

##### National

The secretary reported the correspondence from the A. M. A. office in Washington and the action that had been taken relative to following through with the request for opposition to inclusion of physicians under the Social Security bill.

##### Local

The secretary reported a conversation with a candidate for the state legislature, in which he was seeking the opinion of the Association relative to a bill which he proposed to introduce raising the per diem cost to those who are able to pay for hospitalization in the state mental institutions, and other matters, which he felt should be remedied by legislation. The committee, after discussion, decided that they would take no action on this matter until they saw his definite proposal in writing.

Annual Convention, Indianapolis, October 24, 25, 26 and 27, 1954

The committee reviewed the report of the sale

of exhibit space and complimented the secretary on the amount of space which had been sold.

#### Organization Matters

Request of the American Legion for use of the mailing list of the Association for distributing material relative to the veterans care program was approved on motion of Drs. Clarke and Portteus.

Proposed resolution from Indiana to AMA on recordings. The secretary reported on action of the Committee on Medical Education and Hospitals in which they advised that the Indiana State Medical Association introduce a resolution at the San Francisco meeting of the A. M. A., asking that the A. M. A. undertake recording of the scientific programs given during the A. M. A. meeting. Upon motion of Drs. Portteus and Clauser the secretary was instructed to draw such a resolution for presentation by the delegates at the A. M. A. meeting.

The secretary read a letter covering the agreement between Eli Lilly and Company and the Indiana State Medical Association for the purchase of recording equipment and the basis upon which the Association would work out the investment. This arrangement was approved on motion of Drs. Clarke and Portteus.

The secretary read a letter from the Lake County Medical Society relative to the number of delegates to which the society should be entitled

(Continued on page 798)

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**3:15**—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new FILMTAB\* ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).



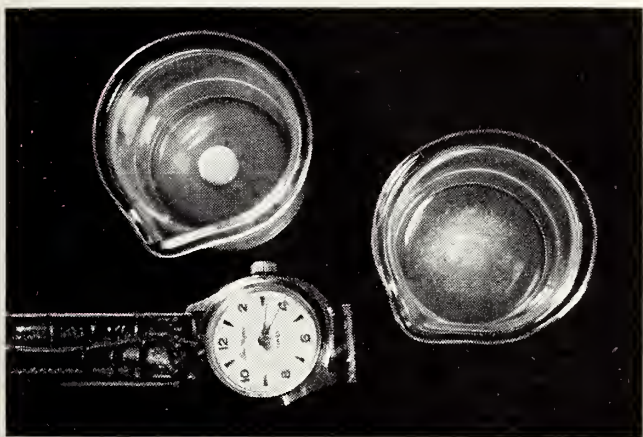
# Earlier Blood Levels *from*



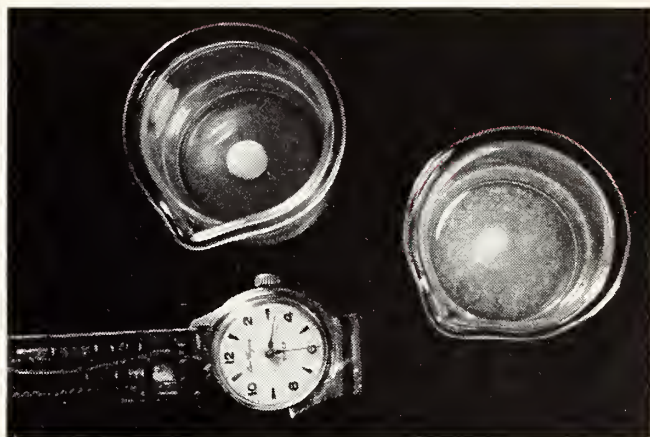
## ERYTHROCIN<sup>®</sup>

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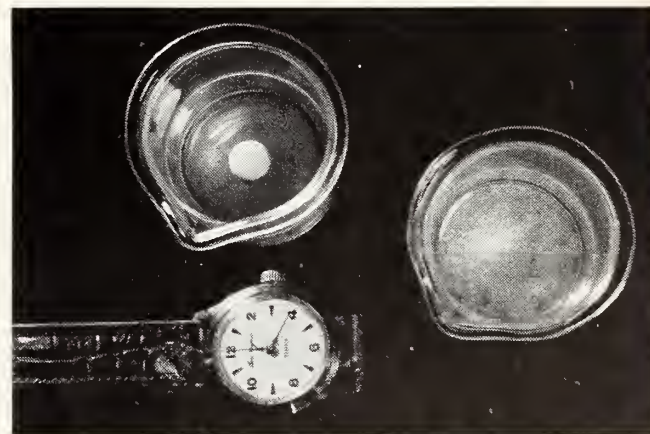
3:20—Five minutes later, *Filmtab\** coating has already started to disintegrate. The tissue-thin film actually begins to dissolve within 30 seconds after patient swallows tablet.



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### Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

### Maplewood—

Most comfortable homes for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

(Continued from page 795)

for the 1954 annual convention, the society claiming that inasmuch as they had 325 members they were entitled to one additional delegate. In discussion the Constitution was read in which it said a delegate is allowed for "each fifty members or major fraction thereof," the attorney ruling that a major fraction thereof would be 26. Upon motion of Drs. Portteus and Clarke this matter is to be referred to the Council and they are to be asked to make a determination or an interpretation of the constitutional statement, "major fraction thereof."

The secretary reported the failure of the office to get any reply from a scholarship student who refused to practice in a community selected by the Association and who was obligated under his agreement to repay the money advanced him to complete his medical education. Upon motion of Drs. Portteus and Clauser the attorney was authorized to take any steps necessary to collect this money and to warn the doctor that if he did not take care of this matter forthwith the secretary would notify the county medical society of his failure to assume this obligation.

Letter from Dean I. Barnhart, Director of Education of the Commission on Alcoholism of the State of Indiana, was read, in which he expressed the desire for the Commission to have time on the state convention program for giving a report on

(Continued on page 800)

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Treatment of the "problem drinker" is more than a sobering-up process; it is a rehabilitative procedure which must be tailored to the needs of the individual.

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## NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.<sup>1</sup> It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.<sup>2</sup> In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: *M. Clin. North America* 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 225.

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the Commission's activities. Upon motion of Drs. Clarke and Clauser this matter is to be referred to the Scientific Work Committee with the request that they might try to work in this program on the Wednesday morning general session.

A letter was read from the American Medical Association regarding the meeting of the International Association of Industrial Accident Boards and Commissions in Quebec, Canada, on October 3 to 7, 1954. By consent, this matter is to be called to the attention of the members of the Committee on Industrial Health with the instructions that if they care to go at their own expense it would be all right but the Association would not refund any expenses for this trip.

Letter from the National Associated Businessmen, Inc., Washington, D. C., was read in which they offered the services of Mr. Joseph F. Leopold of Dallas, Texas, as a speaker for the state convention. By consent, it was agreed that this man might occupy a place on the Wednesday morning general session.

It was discussed as to whether or not the Executive Committee should make any recommendations to the Council concerning scheduling of district meetings so as to avoid as many conflicts as possible. After a full discussion of this matter, upon motion of Drs. Portteus and Clauser it was moved that the matter be brought to the attention of the Council for discussion.

The secretary reported that the request which

was made at the last meeting of the Executive Committee by the Indiana Heart Foundation for approval of the Cardiac-in-Industry program was still unsettled. At the last meeting it was referred to the Committee on Heart Disease and Dr. George M. Cook, chairman, which had been done, but Dr. Cook had been absent from his office and therefore no reply had been heard from the committee.

#### The Journal

*Report on advertising* was accepted by consent:

Total, June, 1953 ..... \$2,270.50

Total, June, 1954 ..... 2,982.97

*Complimentary JOURNAL to senior members*

Since there had been discussion by the Council regarding giving complimentary copies of THE JOURNAL to senior members, the secretary presented the following figures:

On the basis of 1952 publication costs it would cost \$2,607.60 a year to send THE JOURNAL free to 265 members of the Association. Anticipating an increase in cost for the coming year for publication of THE JOURNAL, it is estimated that the cost to give THE JOURNAL to 265 senior members would be \$3,180.00. By consent the committee felt that this would be unwise but would reserve any action by the committee until the matter came before the Council at the July meeting.

There being no further business the committee adjourned to meet again at 6:30 p.m., Saturday, July 24, 1954, at the Student Union Building, Indiana University Medical School campus.



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*Member of the American Hospital Association  
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### For All Types of Nervous and Mental Diseases, and Alcoholism

Five modern buildings, separate for men and women  
Individual rooms. All buildings equipped with radio.  
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Located on the LaGrange road, ten miles from Louisville,  
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T. J. Smith, M.D., Associate





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Distrycin has an important advantage over streptomycin. It has the same therapeutic effect but ototoxicity is greatly delayed. Since the patient is given only half as much of each form of streptomycin as he would have on a comparable regimen of either one prescribed separately, the danger of vestibular damage (from streptomycin) or cochlear damage (from dihydrostreptomycin) is significantly lessened.

Signs of vestibular damage appear in cats treated with Distrycin as much as 100 per cent later than in animals given the same amount of streptomycin.

On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:					
Cat treated with streptomycin shows no nystagmus after whirling.		Vestibular damage % of patients			
		Mild	Moderate	Total	
		Streptomycin	12	6	18
		Dihydrostreptomycin	5	0	6
Cat given the same amount of Distrycin has normal reflex.		Distrycin	0	0	0
		Cochlear damage % of patients			
		Mild	Moderate	Total	
		Streptomycin	0	0	0
		Dihydrostreptomycin	12	3	15
		Distrycin	0	0	0

\*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

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## District Meeting Reports

### First Councilor District

Officers who will serve the First District Medical Society during 1954-55 were elected May 13 in a brief meeting immediately following the Third Annual Tri-State Postgraduate Medical Assembly in Hotel McCurdy, Evansville. They are Dr. Joseph C. Lawrence, Evansville, president; Dr. C. Curtis Young, Evansville, vice-president; Dr. Donald Lashley, Tell City, secretary-treasurer; and Dr. E. L. Fitzsimmons, Evansville, alternate councilor. Dr. Minor Miller, Evansville, is district councilor.

The postgraduate program was attended by more than 250 physicians from throughout the Tri-State area. The morning program included surgical demonstrations in Evansville hospitals. An hour was allotted to view the 18 technical exhibits on display after which three panel discussions were held simultaneously on internal medicine, general surgery, and obstetrics, gynecology and pediatrics.

Following a cocktail hour, dinner was served in the Rose Room with Dr. W. J. R. Camp, professor of pharmacology and toxicology, University of Illinois College of Medicine, and Illinois state toxicologist, as guest speaker. His topic was "Poisonings."

### Third Councilor District

Approximately 65 doctors and their wives, representing the 11 counties of the Third Medical District Society, attended the annual meeting in the Dubois Country Club at Jasper, May 26.

Dr. John Paris, New Albany, was elected district president and will select his own officers. The 1955 meeting will be held in New Albany.

Speakers on the program included Dr. George Lukemeyer, Indiana University Medical Center, who spoke on "Artificial Kidney Operation"; Dr. Patrick Corcoran, Evansville, who discussed the use of drugs in modern medicine; and Ed Klingler, Evansville Press staff writer, whose topic was "Politics and You."

### Ninth Councilor District

The 10 counties comprising the Ninth Councilor District of the Indiana State Medical Association were represented by more than 100 doctors and Auxiliary members at the annual meeting May 12 in the Lebanon Country Club.

A golf tournament was on the morning schedule followed by a buffet luncheon in the clubhouse.

A scientific program was presented in the afternoon with four speakers. Dr. Frank Teague, Indianapolis, spoke on "Common Disorders of the Shoulder"; Dr. J. H. McFadden, Lafayette, discussed "Transfusion Reaction"; Dr. C. A. Stayton, Jr., talked on "Roentgen Diagnosis of Bowel Obstruction"; and Dr. J. C. Katterjohn, Jr., Indianapolis, presented a paper on "Use of X-ray in Obstetrics."

Present district officers will serve until 1955. At that time new officers of Fountain-Warren County Medical Society will also assume the district offices. That society will be host to the 1955 annual district meeting. Present officers are Dr. L. S. Bailey, Zionsville, president; and Dr. Jack Porter, Lebanon, secretary.

Dinner was served at 7 o'clock with entertainment furnished by the Wabash College Glee Club.

### Tenth Councilor District

A day-long visit to Norman M. Beatty Memorial Hospital, Westville, highlighted the spring meeting of the Tenth District Medical Society.

Demonstrations of electric and insulin shock therapy, occupational and recreational therapy in various wards and the gymnasium were given throughout the morning to more than 200 doctors and nurses who attended.

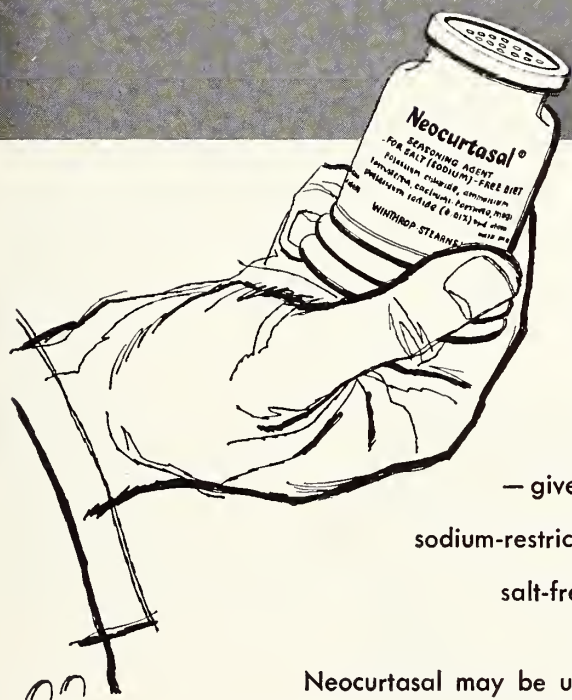
The afternoon program was moderated by Dr. W. R. VanDenBosch, with Drs. Fred W. Tempey, C. L. Rice, R. W. Syler, C. M. Sennett, W. M. Smith, and J. M. Hoyt discussing facts and figures concerning Beatty Hospital,



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maximum security patients, acute intensive treatment, the geriatrics patients, alcoholics, and children as mental patients.

Dr. Francis Girty of the Illinois Psychiatric Institute spoke on "Use and Misuse of Psychiatry in General Practice" and Dr. Virginia Apgar, New York, discussed infant resuscitation and mental effects.

Throughout the afternoon additional demonstrations were given in recreational therapy and in music therapy.

A banquet in the hospital dining room was followed by a tour of the hospital under the direction of Dr. VanDenBosch, superintendent, and a talk by a member of Alcoholics Anonymous.

Dr. Ralph C. Eades, Valparaiso, and Dr. Herbert C. Ashmore, Hebron, president and secretary respectively, of the district society will serve until the fall meeting.

#### Eleventh Councilor District

The scientific program of the ninety-third semi-annual meeting of the Eleventh Coun-

cilor District Medical Society held in Marion at the Veterans Hospital, May 19, was reported to be one of the best ever held in the district.

A panel of doctors from Ford Hospital, Detroit, presented a symposium and round-table discussion of "Medical and Surgical Aspects of Gastroenterology."

Ford staff members who participated were Dr. James Baltz; Dr. Conrad R. Lam, chief of surgery; Dr. Robert J. Priest, associate, department of gastroenterology; and Dr. Brock E. Brush, associate, department of surgery. A 30 minute question and answer period followed their presentation.

A business meeting was held at which Elton R. Clarke, Kokomo, presented his District Councilor's report. It was decided to postpone election of officers until the fall meeting on September 15.

Dinner was enjoyed at the Izaak Walton League camp, near Marion, following an in-

(Continued on page 806)



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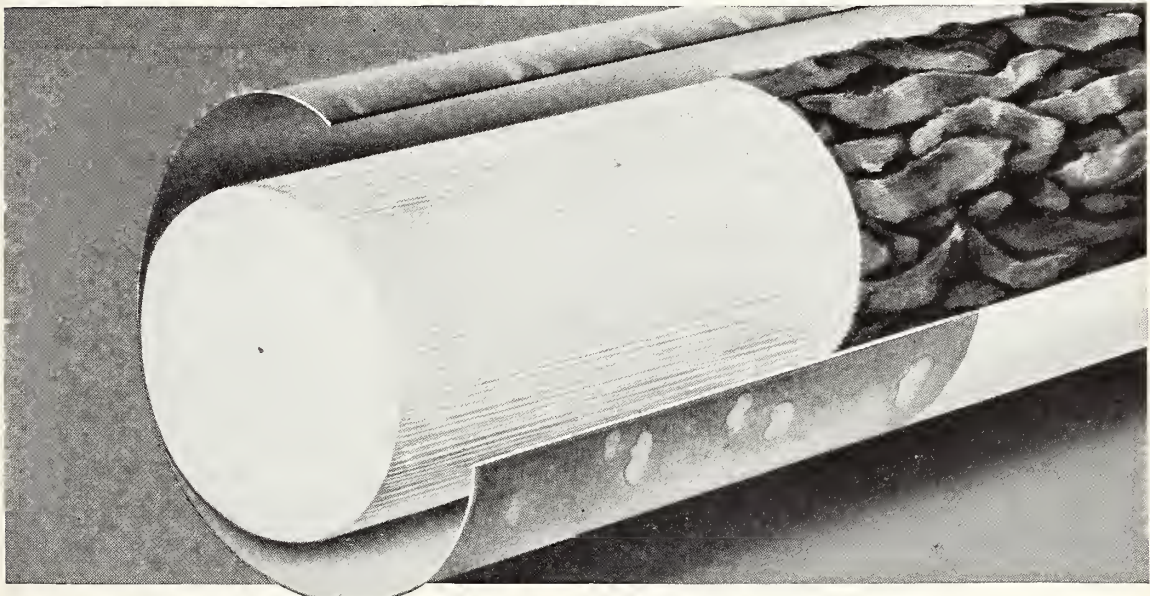
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formal mixer. Music was furnished during the dinner by the Marion Male Chorus.

Thomas A. Hendricks, A. M. A. headquarters, Chicago, was the evening speaker. He discussed current A. M. A. policy and problems of the general practitioners.

The Auxiliary met in the Hostess House, Marion, and during the afternoon made a tour of the RCA plant, returning for a tea at Hostess House, then joining the doctors for dinner.

The Grant County Medical Society served as host to the district meeting. Dr. Lester Renbarger is president. Co-chairmen in charge of arrangements were Drs. R. W. Currie and Russell Lavengood.

Mrs. Renbarger was chairman in charge of the program for the Auxiliary.

#### Twelfth Councilor District

Dr. Robert W. Wilkins, Fort Wayne, will serve as president of the Twelfth District



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Medical Society during 1954-55. He was elected at the annual district meeting held May 19 in the American Legion Home, Columbia City. Also elected for the coming year were Dr. Jack L. Eisaman, Bluffton, vice-president, and Dr. Jules Heritier, Columbia City, secretary-treasurer.

Whitley County Medical Society was host to the 114 doctors and Auxiliary members who registered during the afternoon and evening. A meeting of the Twelfth Medical District Advisory Council to Blue Shield was held at 12:30, with Dr. Frank Thompson, Columbia City, president of this group, presiding. Dr. Walter L. Portteus, president-elect of Indiana State Medical Association was the speaker at the luncheon. Other special guests were James A. Waggener, executive secretary of I.S.M.A., and Kenneth Bush, field secretary for the state association. L. H. Converse of Blue Shield, Indianapolis, presented several topics for discussion by the group.

A golf tournament was held at Crooked Lake Golf Course during the afternoon for the doctors and Auxiliary members heard a book review in the Legion Home.

The district business meeting was held at 6 o'clock with Dr. James Burk, president, presiding. Letters announcing the candidacy of Dr. W. U. Kennedy, New Castle, and Dr. E. H. Clauser, Muncie, for president-elect of I.S.M.A. were read. It was voted to send letters of thanks for this information but to refrain from an endorsement of candidates on the district level.

An invitation from Noble County Medical Society to hold the 1955 district meeting in Kendallville was accepted. The meeting will be held May 18.

A social hour with the Auxiliary members was followed by a joint dinner meeting of the two groups in the Legion Home. Entertainment was furnished by Edwin Baron, hypnotist.



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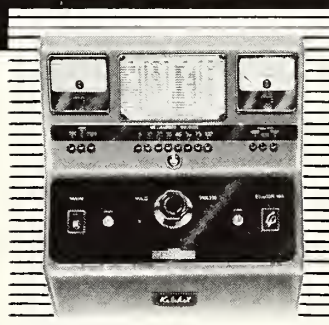
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# News from the County Societies

Dr. Art Schoen, Louisville, presented a paper on "Peptic Ulcer" to 23 members of the **Floyd County Medical Society** at their May 14 meeting in the New Albany Country Club.

At a business meeting following Dr. Schoen's talk members voted to take association membership in Jefferson County Medical

Society in Kentucky and to attend four meetings a year in Louisville as a group.

Robert Amick, field secretary for Indiana State Medical Association, spoke briefly on services available to county societies and to individual doctors through the state headquarters office.

Floyd county doctors pictured below at a recent meeting are (reading from left to right and top to bottom): C. E. Briscoe, W. F. Edwards, A. M. Baker; J. M. Paris, D. M. LaFollette; Dr. LaFollette, P. P. Hess, H. L. Worley, J. Y. McCullough, K. H. Brown; M. W. Roggenkamp, G. S. Pierce; H. W. Byrn, F. K. Allen, N. Wolfe, R. E. LaFollette; P. M. Davis, S. M. Baxter, Wm. H. Garner, and J. P. Gentile.





At its final meeting of the season **Fort Wayne Medical Society** members elected new officers for the coming year and installed Dr. A. J. Roser as president. He was named president-elect last year. Other officers named were Dr. N. H. Gladstone, president-elect; Dr. C. H. Warfield, reelected secretary, and Dr. D. S. Painter, treasurer. Chosen to serve on the board of trustees were Dr. A. R. Savage, immediate past president, Dr. Paul L. Stier and Dr. Wayne R. Glock. Delegates to state convention will be Drs. W. C. Wright and G. H. Somers, with Dr. R. C. Stauffer and Dr. S. C. Michaelis alternates. Harry A. Lehman was retained as executive secretary of the society.

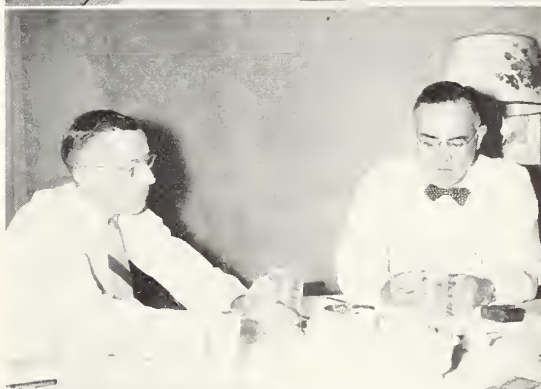
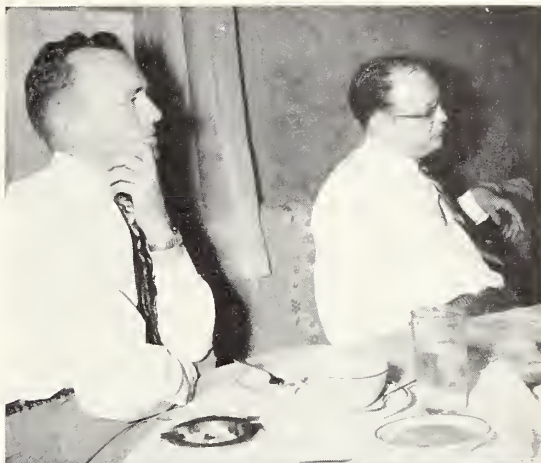
Reports of officers and committees completed the program for the evening which was held in the Chamber of Commerce.

Twenty-six doctors and Auxiliary members of the **Hancock County Medical Society** held a joint dinner meeting in the Hancock County Hospital April 26. Separate meetings were held by each group following the dinner.

At the medical meeting several topics were discussed including a credit rating plan which members will set up.

James A. Waggener, executive secretary of Indiana State Medical Association, gave a report on activities of the state headquarters. He discussed collection problems, joint billing, local, state and federal legislative problems, the use of Blue Shield and hospital accreditation.

A discussion of civil defense was the central topic at the business meeting of the **Henry County Medical Society** held May 27 in the Henry County Hospital, New Castle. Eight-



Reading from top to bottom and left to right above are a group of Deatur County Medical Society members snapped at a recent meeting. They include Drs. L. A. Walker, William Shaffer, Charles Overpeck, W. C. Callaghan, J. T. Morrison and Donald D. Dickson.

teen members were present. Dr. Walter U. Kennedy discussed the social security program and R. J. Amick told of the work done by ISMA in setting up the annual meeting and spoke of the wide variety of scientific talks now available on tape recordings from the state headquarters.





Left to right in top picture are Drs. L. L. Renbarger, president of Grant County Medical Society; M. Arthur Grant, H. Allison Miller, and Robert L. Currie, all members of the society.

The lower group was taken at the same meeting in Marion, April 22, and shows Dr. Renbarger with several other members of the Grant County Medical Society.

**Huntington County Medical Society** members heard staff members of Davis Clinic, Marion, discuss "Diabetes, Its Treatment and Diagnosis" at the May 4 meeting of the group held in Hostess House, Marion. Dr. William A. Clunie, president of Huntington County Medical Society, was in charge of the session. Members of the clinic staff who participated in the panel were Drs. G. Comer Bates, John Woodbury, Henry Alderfer, and John Garrett.

A panel of doctors discussed "Brucellosis and Rabies" at the May 12 meeting of the

**Johnson County Medical Society.** Thirty-four doctors and Auxiliary members attended the dinner meeting in the Country Club.

Panel members were Dr. Robert Boren, DVM, Greenwood, who discussed the topic from the veterinarian's standpoint; Dr. Helen Barnes, who gave the Indiana State Board of Health recommendations for prevention and treatment; and Dr. John Machledt, Whiteland, who discussed the medical symptoms and treatment of brucellosis. A lengthy discussion period followed the talks.

A short routine business meeting was held.

**Knox County Medical Society** members gave unanimous approval to the proposal that society members assist the civil air patrol in giving immunizations. In another action, the society set up a \$150 per year scholarship for a student nurse at Good Samaritan Hospital. Announcement was made that the Road Show by the Indiana Academy of General Practice will be held November 18, 1954 instead of the regular November meeting.

The business meeting followed a dinner May 18 in the Orchard Room of the Grand Hotel, Vincennes, with 26 members attending.

The June 14 meeting was to be the annual party for members and their wives and was to be held in the Vincennes Country Club.

"Bronchogenic Carcinoma" was the title of the paper presented to members of **LaPorte County Medical Society** May 20 by Dr. George W. Holmes, Northwestern Medical School, and Illinois Central Hospital, Chicago. The dinner meeting was held in the Spaulding Hotel, Michigan City, with 31 attending. The speaker was reported to be excellent. In a brief business meeting a \$50 gift to the National Society for Medical Research was voted.

The next meeting of the society will be held on September 16 at the Kingsbury Ordnance plant.

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**Madison County Medical Society** held its last meeting until fall on May 17 in the Anderson Country Club. Forty members attended the dinner meeting at which Dr. John V. Thompson, Indianapolis, was the guest speaker. He discussed "Recent Advances in Cardio-Pulmonary Surgery."

At a business meeting it was decided to take no action as a society on the request of

the Civil Air Patrol regarding immunization in case of an emergency. The matter of vaccinations was to be decided by the individual physicians.

The next meeting will be held September 20 in the Anderson Country Club.

At a business meeting of the **Miami County Medical Society** held April 30 in Veach's Restaurant, Peru, members discussed the possibility of meeting with the Wabash County Medical Society for purposes of stimulating better scientific programs. The plan, if adopted, would be to alternate the programs.

Kenneth W. Bush, field secretary for Indiana State Medical Association, spoke on





field service, legislation, tape recordings and recorders, Rural Health committee activities, the Council approved public relations program and malpractice insurance. There was general discussion of some of the topics following his talk.

Fifteen members attended the meeting.

A film, "Toxemia of Pregnancy" was shown at the May 23 meeting of **Morgan County Medical Society** in Muriel's Cupboard, northwest of Martinsville. Nine members attended the dinner meeting.

A short business meeting was held at which

At a meeting April 30 in Peru several informal groups were photographed. Pictured on the opposite page they are, left: Drs. Theodore Person, Samuel J. Ferrara, Earl L. Waite; Stephen D. Malout, P. C. Damiani, John B. Berkebile, E. L. Burrous; Homer E. Line and R. E. Barnett.

Right hand pictures show Drs. Donald W. Ferrara, Leonard D. Lewis; Harold E. Rendell, president Miami County Medical Society; Owen Johnson, Ethan E. Sehrock, secretary of society; and C. R. Herd.

it was voted to send telegrams to Washington protesting the administration's social security plans. Dr. Horace R. Willan was named to represent Morgan County on the Council for Children and Youth.

The next meeting was scheduled for July and was to be held in the home of Dr. David Eisenberg.

**Noble County Medical Society** met at noon, May 3, in Mrs. Linder's Restaurant, Kendallville, with 16 members present.

At a business meeting several communications from other county societies were read and discussed and a brief talk was made by Kenneth W. Bush, ISMA field secretary, who discussed organizational matters and stressed the services which are available from state headquarters.

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Twenty-eight members of **Owen-Monroe County Medical Society** met for dinner and a meeting in the Bloomington Country Club April 29. A representative of the State Board of Medical Registration and Examination was present and discussed briefly the activities of the board.

A discussion of the community hospital needs followed.

The **Shelby County Medical Society** held a joint dinner meeting with dentists of the county in the Elks Club, Shelbyville, May 12. Twenty-four members were present.

Following the dinner Dr. C. G. Weigand, Indianapolis, spoke on "Manifestations of Vitamin Deficiencies."

Members of **Tippecanoe County Medical Society** met April 13 for an evening meeting at which Dr. A. L. Marshall, Indiana State Board of Health, Indianapolis, spoke on the poliomyelitis immunization program. His talk was followed by a question and answer period.

Dr. K. O. Neumann, president, presided at the business meeting following dinner in Lincoln Lodge. A number of communications were discussed. Dr. J. A. Bush was accepted as a member of the society, plans for an April 22 Cancer Clinic at St. Elizabeth's Hospital, Lafayette, and for the Ninth District Medical meeting were announced.

The next meeting was to be held in the 40 & 8 Clubhouse with Albert Stump, Indianapolis, as guest speaker.

Following the business meeting, members went to the Country Club to view a film.

Dr. Hubert T. Goodman gave a detailed report on the situation in Washington concerning legislation of interest to the medical profession at the May 11 meeting of the **Vigo County Medical Society** in St. Anthony's Hospital, Terre Haute. Twenty-three members attended.

Robert Amick, ISMA field representative, gave some information on the trips planned for Indiana doctors to the AMA convention, discussed headquarters' services and the annual convention.

**Wabash County Medical Society** held the May 12 meeting in the Honeywell Memorial building with Dr. Joseph W. Davis, Marion, as the guest speaker at the dinner. He spoke on the work of the American College of Surgeons committee on trauma, whose purpose is to improve the care of the injured and promote safety measures. The committee is being expanded to the county level throughout the United States.

Thirty-five members of **Wayne-Union County Medical Society** attended a dinner meeting in Reid Memorial Hospital, Richmond, May 13. The program consisted of the showing of two films, one on the use of cortisone and the other on the intra-articular use of hydrocortisone. Members of the society were also invited to attend a surgical staff meeting at the hospital on the subject of gastro-duodenal hemorrhages.

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Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication of THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 10th of the month preceding date of issue.

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1. Parsons, L., and Tenney, B., Jr.:  
M. Clin. North America 34:1537,  
1950.

2. Greenblatt, R. B.: J. Clin. Endocrinol. & Metab. 13:828, 1953.

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Medical society-sponsored television programs again will be spotlighted as problems of producing and promoting them are discussed. Special emphasis will be given to putting on a series of TV programs.

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Other sessions of this "idea exchange" will be geared to—offering A.M.A. departments the benefit of constructive suggestions on improving services to local medical societies . . . hearing about a unique method worked out by a county society for selling physicians and the community on its PR program . . . receiving first-hand reports on several new PR projects.

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## I.U. TRUSTEES APPROVE FACULTY PROMOTIONS AT MEDICAL SCHOOL

**P**ROMOTIONS have been approved by the Indiana University board of trustees for six full-time and eleven part-time members of the faculty of the Indiana University School of Medicine, it has been announced by Dean John D. Van Nuys.

Dr. Louis H. Segar, who retired July 1 after having been a part-time member of the medical school staff since 1916, was given the title of professor emeritus of pediatrics.

The full-time faculty members promoted as of July 1 and their new ranks are:

Drs. Virgil K. Stoelting, chairman and professor of anaesthesiology; William A. Summers, associate professor of microbiology; Paul R. Lurie, associate professor of pediatrics; James

S. Battersby, associate professor of surgery; David C. Gastineau, assistant professor of radiology; and John Russell, assistant professor of surgery.

Promotions of part-time staff physicians include the following:

Mortimer Mann, associate professor of ophthalmology; Irving Rosenbaum, assistant professor of pediatrics; Andrew C. Offutt, assistant professor of public health; William E. Sutton, associate in genito-urinary surgery; John E. Heubi and Donald L. Rogers, associates in pediatrics, and Joseph Finneran, instructor in surgery; and Arnold W. Kunkler, Charles McKeen, and Don Moore, all resident instructors in surgery.

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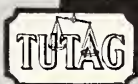
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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, October 11  
Surgical Anatomy & Clinical Surgery, Two Weeks, August 23, October 25  
Surgery of Colon & Rectum, One Week, September 13  
Basic Principles in General Surgery, Two Weeks, September 20  
Breast & Thyroid Surgery, One Week, October 25  
Thoracic Surgery, One Week, October 11  
Esophageal Surgery, One Week, October 4  
General Surgery, Two Weeks, October 4; One Week, October 4  
Gallbladder Surgery, Ten Hours, October 25  
Fractures & Traumatic Surgery, Two Weeks, October 25

**GYNECOLOGY**—Office & Operative Gynecology, Two Weeks, September 20  
Vaginal Approach to Pelvic Surgery, One Week, September 13

**OBSTETRICS**—General & Surgical Obstetrics, Two Weeks, October 4

**MEDICINE**—Two-Week Course, September 27  
Electrocardiography & Heart Disease, Two Weeks, October 11  
Gastroenterology, Two Weeks, October 25  
Gastroscopy, One Week, September 13

**RADIOLOGY**—Diagnostic Course, Two Weeks, October 4  
Clinical Uses of Radio Isotopes, Two Weeks, October 4

**PEDIATRICS**—Clinical Course, Two Weeks, by appointment.  
Congenital & Rheumatic Heart Disease in Infants & Children  
One Week, October 11 and October 18  
Two Weeks, October 11

**UROLOGY**—Two-Week Urology Course, September 20  
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## International Surgeons to Meet September 7-10 in Chicago

The Nineteenth Annual Congress of the United States and Canadian Sections of the International College of Surgeons will be held in Chicago at the Palmer House September 7 through 10. Advance registration, business and Auxiliary meetings will be held September 6.

General assemblies will be held on the four mornings and afternoons and will be addressed by prominent surgeons from the United States, South America and Europe. A luncheon meeting each day will feature panel discussions led by the morning speakers.

Evening meetings include a Film Forum, under the chairmanship of Dr. Philip Thorek, Chicago; a Forum on Lung Cancer being arranged by Dr. Morris Fishbein; the annual banquet, which will be in celebration of the dedication of the Surgeons Hall of Fame; and the annual Convocation at Chicago Civic Opera House, when the speaker will be Dr. Robert L. Johnson, Philadelphia, president of Temple University.

Special section meetings and luncheons have also been planned according to L. G. Jackson, coordinator of public relations. Offices of the United States chapter are at 1516 Lake Shore Drive, Chicago 10, Illinois.

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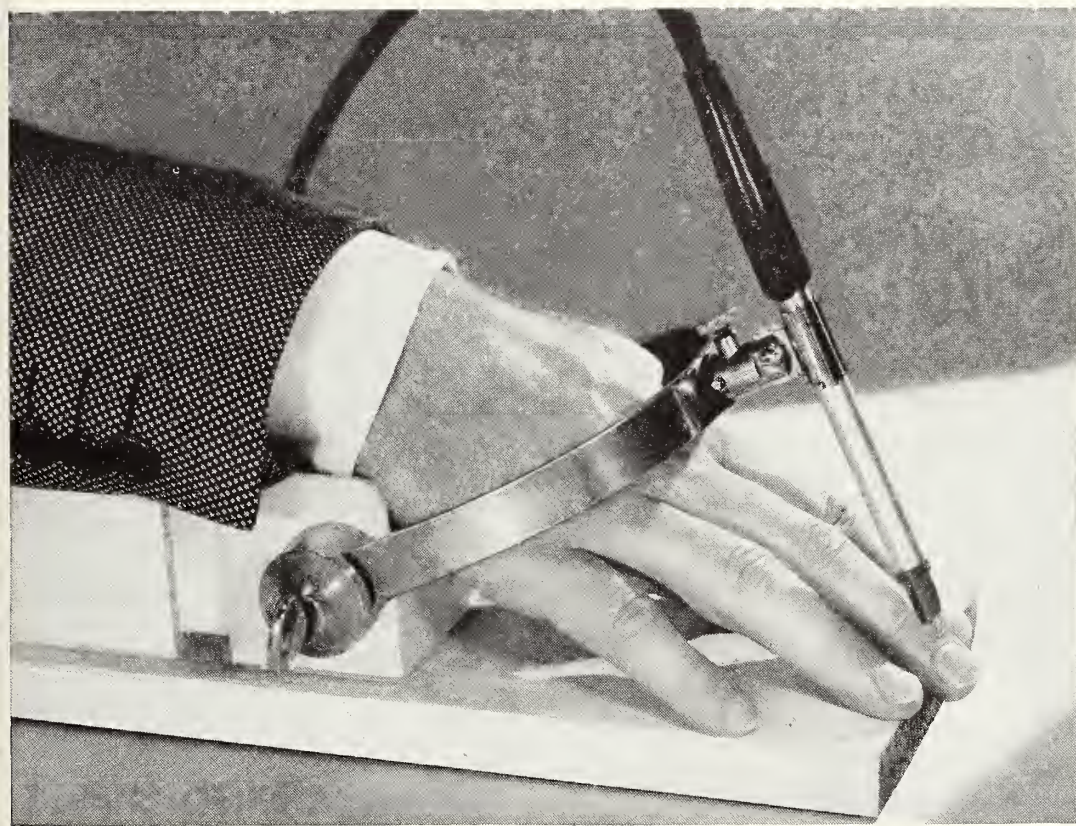
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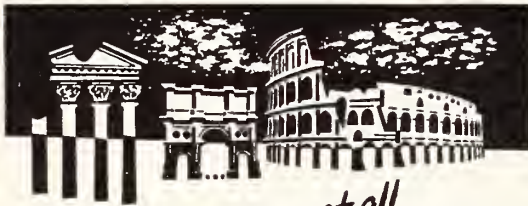
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## OB-GYN Certification Changes Announced

Applications for certification, American Board of Obstetrics and Gynecology, for the 1955 Part I examinations are now being accepted and must be received by the secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio, by October 1.

Under a change of requirements candidates must submit 20 case abstracts rather than 25 as formerly. Five of these may be from candidates' residency service.

All candidates are required to submit with their application, a plain typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application or the year prior to their request for reopening of their application, with the diagnosis, pathological diagnosis, nature of treatment and end result.

Mike Coxey, whose thromboangiitis obliterans dates back fifteen years, has lost, one by one, his right leg, his left leg, and, in succession, eighteen of the twenty-eight phalanges in his ten fingers. He has remained, through these periodic diminishments, an avid two-packs-a-day smoker, although for the last two years his only remaining prehensile equipment has been the apposed stumps of his right fourth and fifth fingers.

Today he presented himself with full-blown gangrene of the fifth finger stump, still defiantly puffing on a cigarette wedged into the web.

"Well, Doctor," he said through a meditative smoke ring, "it looks like you're going to have your way at last. Soon as they chop off my pinkie I can't hold a butt no more so I'll quit smoking and we'll see if I get better then."

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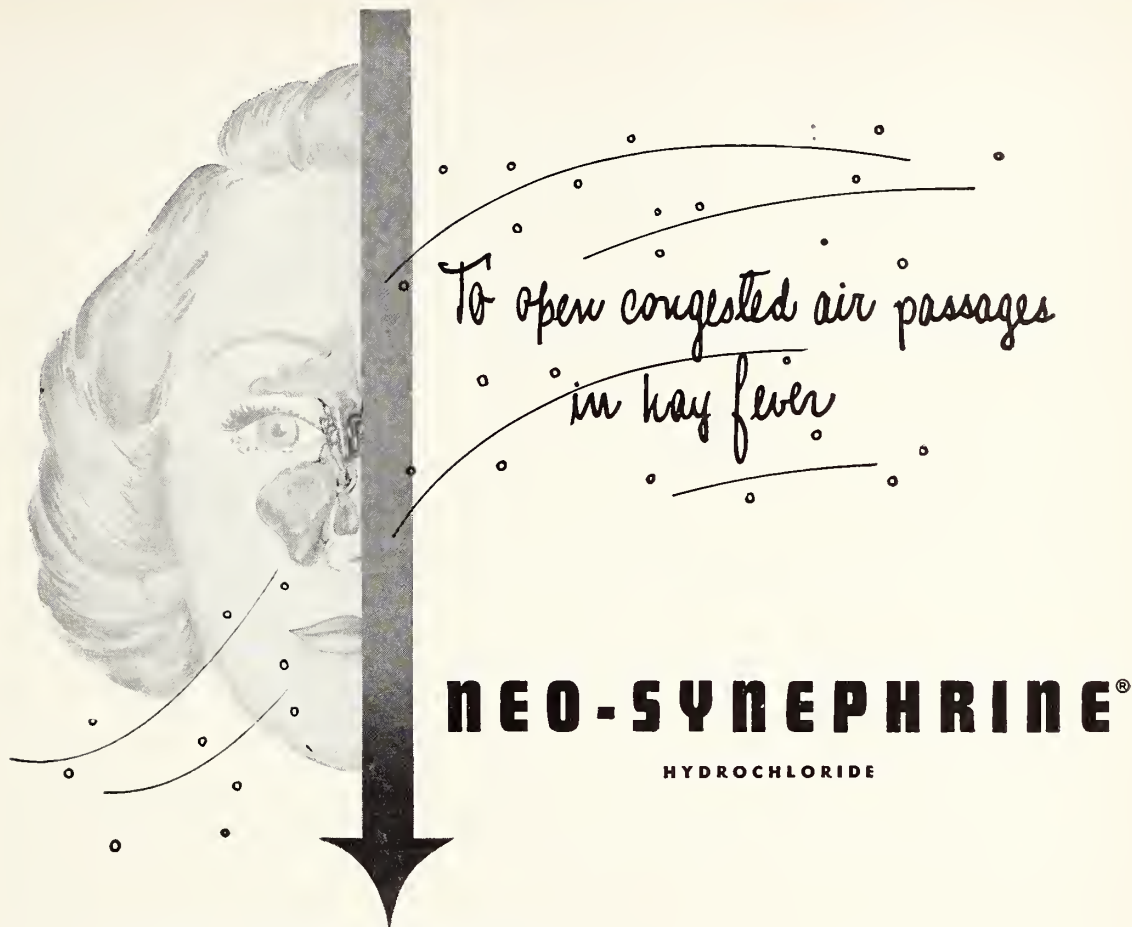
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I. Van Alyea, O. E., and Dannelly, Allen: Arch. Otolaryng., 49:234, Feb., 1949.

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

## THE MONTH IN WASHINGTON

WASHINGTON, D. C.—During the next three years the federal government expects to help finance the construction of thousands of new medical and dental facilities—diagnostic-treatment clinics, vocational rehabilitation centers, nursing homes, and chronic disease hospitals. Only three strings are attached: the facilities must be non-profit, they must be under medical or dental supervision, and local communities must raise part of the cost.

Legislation establishing the new program was enacted just as Congress plunged into its adjournment rush, and before it had come to final decisions on reinsurance and other major controversial bills in the health field.

The new operation was authorized by amending the Hill-Burton Act (passed in 1946 to assist hospitals) to permit grants to units that do not qualify as hospitals. Under the original Hill-Burton law, grants could be made to rehabilitation centers and diagnostic-treatment clinics only if they were attached to hospitals. Grants could also be made to chronic disease hospitals. The new law authorizes help to centers and clinics operating on their own, a provision Public Health Service expects to be of particular assistance to smaller communities. It also offers aid to nursing homes, which previously were not covered.

In the case of chronic disease hospitals, it is explained that the law offers two new inducements for construction: 1. Money is allocated to the state and earmarked for this particular type of hospital. 2. The federal government will be able to pay 50% or more in all cases, whereas under the old law the U. S. share was as low as one-third in some of the higher-income states.

Grants to clinics, centers, and nursing homes

will have to wait on state surveys to determine priorities, according to U. S. hospital officials. However, if local sponsors take the initiative, grants can be processed immediately for chronic disease hospitals, as earlier Hill-Burton surveys have established their priorities. Failure of communities to construct chronic disease hospitals was one of the disappointments of the first Hill-Burton program.

The first year's appropriation will be \$37.4 million, increasing over the next three years until the total authorization of \$182 million has been reached. The new projects in no way interfere with the regular Hill-Burton grants for construction of hospitals, for which \$75 million is available this year.

The final flurry over the reinsurance bill was preceded by a concerted drive by the administration. The President himself interceded with insurance company officials, and Secretary Hobby agreed to amendments in an effort to satisfy the state insurance commissioners. The commissioners, who would have an important role in administering the reinsurance program, at first had flatly opposed it. President Walter B. Martin and other A.M.A. officials were called in for a discussion of reinsurance at the Department of Health, Education, and Welfare, and later Sherman Adams, assistant to the President, also invited Dr. Martin to a White House meeting on the same subject.

### BILLS STRANDED

As expected, bills for a new program of medical care of military dependents were left stranded when adjournment time approached. Before he introduced his bill on the subject, Chairman Dewey Short of the House Armed



Services Committee insisted that Defense Departments estimate first year's additional cost of the program. The estimate was \$67 million.

The military scholarships bill met the same fate—too much time taken up in drafting a version that would satisfy all executive departments. Under this plan the Defense Department would grant tuition-and-maintenance scholarships to medical and dental students, in exchange for pledges to spend one year in military service

for every subsidized year of training. Both bills are certain to reappear next session.

For the current fiscal year, the Department of Health, Education, and Welfare has available \$1,663,413,761. The appropriation bill is \$10,-904,500 more than the administration requested but under last year's budget of \$1,927,432,261 (the decline explained by decreased public assistance grants to states). Public Health Service has \$228,060,000 for its regular programs.

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### MEDICINE MOVING TO THE COUNTRY

Medicine at the grass roots is destined to undergo tremendous changes in the years ahead. Never has the county medical society been presented with such opportunity nor with so much responsibility. Good medicine is moving to the country. If leaders in local societies are able to read the signs of the times and act with vision, the results will be little less than revolutionary.

To plan medical care for an entire state which includes industrial and rural populations is an almost impossible task, but to survey and organize the medical care for the people of a single county is within the realm of possibility and something that can and should be done. The group that can do it are the doctors serving the area.—George A. Collett, M. D., in Surgery, Gynecology and Obstetrics.

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# Journal

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Supervised by THE COUNCIL

Volume 47 — August 1954 — Number 8

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## THE STORY OF RESERPINE\*

RICHARD B. MOORE, M.D.

WILLIAM J. PIERCE, M.D.

A. D. DENNISON, JR., M.D.

*Indianapolis*

**R**AUWOLFIA SERPENTINA, a plant that has been used as a medicinal agent for several centuries, is classified as belonging to the family *Apocyanaceae*. In the seventeenth century, Plumier gave the name *Rauwolfia* to a new genus of the Apocyanaceous family in honor of the German physician and botanist, Leonard Rauwolf, who had made a scientific expedition to Asia and Africa in the years 1573-1575 to study medicinal plants which had previously been mentioned by Greek and Arabic writers. (Rauwolf published the results of his studies in book form in 1581.) Since that time, 125 different species of this genus, *Rauwolfia*, have been described. Of these, only 12 have been studied extensively.

The species *serpentina* derives its name from its use as an antidote to the bites of poisonous reptiles. In Sanskrit writings it is known as

'Sarpagandha', 'Chandrika', or 'Chandra.'<sup>1</sup> 'Sarpagandha' means repellent to snakes; 'Chandra' is the Sanskrit equivalent of 'moon.' It is well known that insanity has long been called 'the moon disease', or moon sickness. *Rauwolfia serpentina* thus derives its name from one of its original medicinal uses, that of being a remedy for snake bites; we find another of its original uses in the alternative native name, 'Chandrika', indicating its use in the treatment of insanity.

*Rauwolfia serpentina* is found in tropical and sub-tropical areas, and it generally grows in a rich soil. It grows quite abundantly in the tropical Himalayas and in the plains and foothills of northern India. It is a small, erect, glabrous shrub from one-half to three feet in height, having white bark or white or pinkish flowers, and crooked, tapering roots measuring from one-fourth to one-half inch in diameter.<sup>2</sup>

The roots, leaves, and juice of this plant have been considered of medicinal value for several centuries, and these uses attracted the attention

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\* Lilly Laboratory for Clinical Research, Indianapolis General Hospital, Indianapolis, Indiana.



of Indian and Malayan physicians in the last century. An infusion of the root was considered to be an antihelminthic in Java. According to Raumphius, the juice of the leaves was used extensively in India and Java as a remedy for corneal opacity. As mentioned previously, the root has been employed as a remedy for the bites of poisonous snakes and insects, both internally as an infusion of the root, and externally as a paste. Drymock stated in 1890<sup>3</sup> that most of the people of the laboring classes who came to Bombay from the northern provinces proclaimed the beneficial effects produced by the root in all forms of bowel disorders. It was utilized in diarrhea and dysentery; and in cases of cholera it was used in combination with other roots and herbs. This plant had a reputation as an ecboic and as an agent employed during and after childbirth because of its supposed stimulation of the uterus. There is no mention of the hypnotic and sedative action of this root in the older literature on Indian medicinal plants. However, its use in insanity was known among the people for centuries. This plant is particularly known in the bazaars of the northern part of India as 'pagla-ka-dawa,' or 'insanity herb.'<sup>4</sup>

The sedative and hypnotic effect of this plant appears to have been recognized first by the poorer classes of people in India. It was used to put children to sleep, or at least to sedate them, while their mothers were away working in the fields. This practice is stated to be present among some of the people of India today. In 1931, P. C. Roy described the hypnotic action of *Rauwolfia serpentina*, and reported the results of his pharmacologic studies of this plant.<sup>5</sup>

The most important pharmacologic property of this interesting plant was not discovered until 1931, when an Indian physician, Ganneth Sen, described its hypotensive effect.<sup>6</sup> It took Dr. Sen many years to identify the drug which he

knew the people of this area to be using as a sedative in insanity, hysteria, epilepsy, and insomnia. In 1931 Sen and Bose reported the use of *Rauwolfia serpentina* in insanity and hypertension.<sup>6</sup> They found that in insanity with marked maniacal symptoms, the drug often gave relief of these symptoms within several days, and that these patients were much easier to handle. They noted that in the plethoric and nervous type of patients with hypertension, such symptoms as headache, sense of heat, and insomnia disappeared quickly, and that the blood pressure was reduced within one or two weeks. In a few patients having high fevers, its use resulted in a decrease in the fever and tachycardia. They also mentioned its use after parturition as an agent to insure firm uterine contractions.

*Rauwolfia serpentina* was probably first investigated chemically by Eykman in the Dutch East Indies as early as 1887, and by Greshoff in 1890.<sup>7, 8</sup> It was occasionally studied during the first 30 years of this century, but the first definite chemical study made of this plant was by Siddiqui and Siddiqui of Delhi, India, in 1931.<sup>9</sup> They isolated and described five principle alkaloids of *Rauwolfia serpentina*. Further studies by these investigators<sup>10, 11, 12</sup> and by van Itallie and Steenhauer<sup>13</sup> and by Schlittler, Mueller and Bein<sup>14</sup> and by others have revealed a total of 15 alkaloids isolated from this plant. In 1944, Gupta, Kahali, and Dutt found that the resinous non-alkaloidal fraction extractable from *serpentina* roots exerted the characteristic sedative action of crude *Rauwolfia* extracts.<sup>15</sup> Following this, in 1952, Schlittler, Mueller and Bein isolated an alkaloid which they named reserpine.<sup>14</sup> This alkaloid is contained in the oleoresin fraction of *Rauwolfia serpentina* and has been isolated from several other species of *Rauwolfia*. Drs. Norbert Neuss, Harold Boaz, and James Forbes, of the Lilly Research Labora-

stories, were the first in this country to describe the empirical formula for reserpine in a scientific journal.<sup>16</sup> (See Figure 1.) To date, there has been no evidence that the hypotensive and the sedative effects can be ascribed to different components of *Rauwolfia serpentina*, and *reserpine* is the most potent single alkaloid so far studied, and appears to produce all of the effects of the crude root.

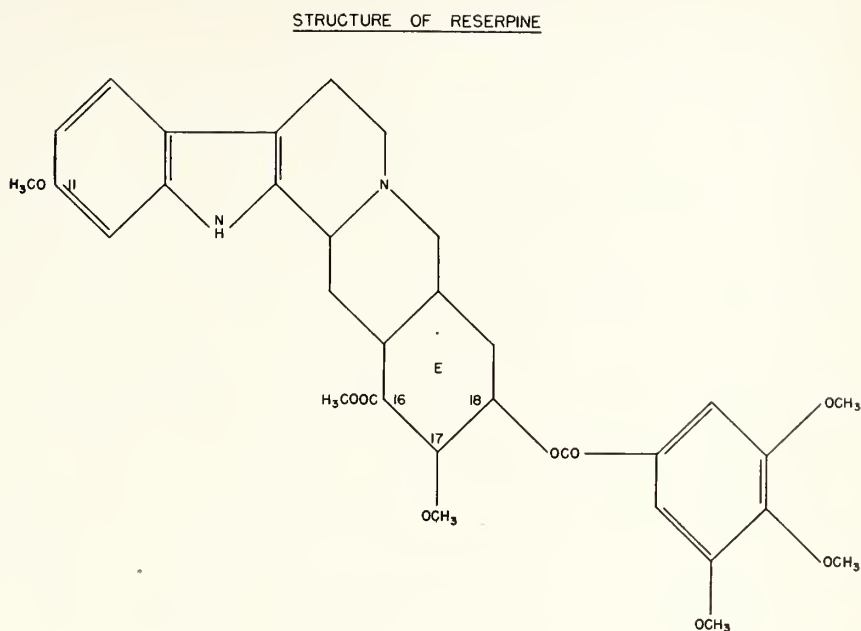


Figure 1

In 1931, Sen and Bose first described the pharmacologic properties of *Rauwolfia serpentina*.<sup>6</sup> Also in this year, P. C. Roy described some pharmacologic effects of this drug in animals.<sup>5</sup> Further studies were done by Chopra, Gupta, and Mukherjee in 1933,<sup>4</sup> by Raymond-Hamet in 1936, 1940, and 1946,<sup>17, 18, 19, 20, 21</sup> by Chopra and Chakravarti in 1941,<sup>22</sup> by Chopra *et al.* in 1942 and 1943,<sup>23, 24</sup> and by many other European and American investigators since then.

(1) One of the most important pharmacologic effects of reserpine is its sedative action. Small doses given to various animals result in a state of quietude, a decrease in spontaneous activity, and a reduction of emotional response lasting for 8 to 24 hours. Larger doses result in quiet sleep, but the animals may be awakened by tactile or other external stimuli, only to fall asleep again after the stimulus has ceased.

(2) There is no analgesic action. The corneal and the pinch reflexes remain intact.

(3) Muscular coordination is not affected, which is in contrast to the incoordination produced by barbiturates.

(4) Neuromuscular transmission is not altered.

(5) There have been no alterations reported in the electro-encephalogram, which is in con-

trast to the characteristic changes in the EEG produced by barbiturates.<sup>25</sup>

(6) Another very important pharmacologic effect of this drug is its hypotensive action. In animals, reserpine induces a gradual and moderate fall in arterial blood pressure, which occurs after a latent period and lasts for a long period of time. This hypotensive effect cannot be increased beyond a certain degree regardless of large increases in dose.

(7) Bradycardia is produced, and this effect may be abolished or blocked by atropine.

(8) In animals, this drug causes an increase in the depth of respirations. In large doses the respiration is depressed, and the animal may die of asphyxia.

(9) There is increased intestinal motility and tone, and diarrhea may result.

(10) In animals there results an increase in the secretion of gastric hydrochloric acid, which may be blocked by an anticholinergic compound.<sup>26</sup> No definite effect on gastric secretion has been reported in humans as yet. Further work is being done on this matter and shall be the subject of a later report.<sup>44</sup>

(11) In animals, miosis is one of the first effects to be observed, and is one of the last to

disappear. Relaxation of the nictitating membrane, as well as ptosis and lacrimation, occur in animals. Recently, Rubin and Burke have described a simple bio-assay for reserpine-like activity of *Rauwolfia serpentina*, and other species of *Rauwolfia*, utilizing the graded ptotic responses of albino mice to a single dose of the test substance.<sup>27</sup>

(12) There appears to be a disturbance in the heat-regulating center in animals. They usually show a reduction in body temperature and exhibit shivering and shaking at times. There is no antipyretic effect as was originally believed, and the drug is of no value as a febrifuge, although it had been used in this capacity in the past.

The actual site of action of reserpine is not definitely known. There is much evidence to suggest that it acts on the central nervous system, and probably within the hypothalamus in particular. There has been no good evidence of any vasodilator activity of reserpine. There is no ganglionic blocking action. There is no peripheral sympatholytic action, and reserpine enhances the pressor effects of epinephrine and nor-epinephrine rather than inhibiting them. The hypotensive action of this substance is not altered by cutting the vagi and depressor nerves, and is not inhibited by atropine. Reserpine does not enhance the blood pressure lowering resulting from the intravenous administration of acetylcholine to animals. This drug antagonizes pressor responses from central vagal stimulation and carotid occlusion, but fails to inhibit the pressor response resulting from increased intracranial pressure (which acts through asphyxial stimulation of the vasomotor center). Whether the actual method of action is due to a blocking of the synaptic transmission through the central part of the autonomic nervous system between afferent and efferent neurons, or to a diminution of sensitivity of central sympathetic portions is not known. But it does appear that the primary site of action of reserpine is in the hypothalamus.

In 1931, Sen and Bose first reported on the hypotensive effect of *Rauwolfia serpentina*.<sup>6</sup> Their observations stimulated extensive use of this drug in the treatment of hypertension in India and in England in the following years. In 1942, Bhatia reported on the use of this drug in

hypertension in 20 patients.<sup>28</sup> He concluded that it is particularly helpful in relieving the nervous symptoms of hypertension, such as headache, tinnitus, vertigo, giddiness, and insomnia. In 1943, Gupta, Deb, and Kahali reported the use of a standardized extract in different types of mental disorders, including epilepsy.<sup>29</sup> Their patients were more easily cared for, had improvement in appetite and in bowel function, slept more normally, and there was a decrease in the number and severity of epileptic seizures. In 1949, Vakil confirmed the value of this drug in hypertension based upon his 10 years of experience.<sup>30</sup> He stated that almost all Indian physicians felt that *Rauwolfia serpentina* was the most effective drug they had employed in the treatment of this condition. Vakil reported a critical study of 47 patients treated with the dried root, and found a good hypotensive response in 38 of these cases after four weeks of treatment. He pointed out the need for a more standardized preparation of the drug.

The first report of the use of this drug in hypertension in the United States was made in 1952 by Wilkins, Judson, and Stanton.<sup>31, 32</sup> They demonstrated that the single alkaloid, reserpine, produced all of the desirable effects of the crude drug, including hypotension, bradycardia, and relief of headache, dizziness, palpitation, nervousness, irritability, and anxiety. In 58 patients studied, there was an average drop in blood pressure from 191/109 to 167/94 mm. Hg, and an average decrease in pulse rate from 85 to 75 per minute. Wilkins felt that reserpine was particularly useful in young, labile, psychoneurotic hypertensive patients with tachycardia. He also stated that it is an excellent adjunct to other more potent hypotensive agents. These workers noted several side effects, none of which was considered serious. These were: nasal stuffiness, a tendency to gain weight, and with higher doses of the drug, diarrhea, nightmares, and agitated depression.

In 1953, Travis Winsor reported the use of reserpine in a small group of patients having essential hypertension.<sup>33</sup> After eight weeks of continuous medication with an average daily dose of 0.5 mg., he noted an average decrease in systemic blood pressure of 24 mm. systolic and 18.1 mm. diastolic, and an average decrease in pulse rate of 8 beats per minute. The blood pressures



returned to control levels in a period of  $2\frac{1}{2}$  to  $3\frac{1}{2}$  weeks after the medication was discontinued. No evidence of resistance to the drug was found in five patients receiving it continuously for three months. Side effects were encountered in some patients receiving more than 0.5 mg. daily. The most common was lethargy, which could be relieved with coffee or with small doses of dextroamphetamine. Others were aching in the arms and legs, nasal stuffiness or obstruction, with and without rhinorrhea, dizziness, dreams and dyspnea at rest. Winsor stated that reserpine did not produce postural hypotension in any of this group.

Hughes and his co-workers recently studied a group of 45 unselected ambulatory hypertensive patients treated with reserpine.<sup>34</sup> They found a significant reduction in blood pressure (a decrease of 20 or more mm. of Hg. in the same arterial blood pressure) in 55 percent of those treated for one month, and in 53 percent of those treated for two to six months. Approximately 30 percent of the patients became normotensive, although all of these had control diastolic blood pressures of 100 to 120 mm.Hg.

Recently, Winsor reported a study of reserpine in combination with other hypotensive agents.<sup>35</sup> He concluded that the combination of reserpine and hydralazine was the best in lowering the diastolic pressure. Dr. John Moyer reported favorable results with this combination, but he also stated that reserpine in combination with hexamethonium gave good results in more severe cases.<sup>36</sup> He reported no significant alteration in renal hemodynamics with the use of reserpine alone.<sup>37</sup>

In February of this year, Dr. Edward D. Freis stated that the nasal congestion caused by reserpine could be relieved by an antihistamine used orally or used locally as a spray. He also mentioned favorable results with the combined use of reserpine and hexamethonium.<sup>38</sup>

Raymond Harris recently reported the use of reserpine in 26 elderly hypertensive patients, and found that most of them became less nervous and apprehensive, and had fewer complaints of headache and dizziness while receiving this drug. A mild hypotensive effect was exhibited, and it is worthy of note that bradycardia occurred even

in patients without an appreciable drop in blood pressure.<sup>39</sup>

Dr. Robert Greenblatt has reported the use of reserpine in certain gynecologic problems.<sup>40</sup> He found this drug to have a mild calming and sedative effect in tension states, premenstrual tension when not accompanied by edema, and in the menopausal syndrome, especially when hypertension is co-existent. He mentioned that this drug has been helpful in the treatment of nymphomania as well as in frigidity.

Recently, Dr. Hoobler reported two cases of phlebotrombosis occurring in patients receiving reserpine.<sup>41</sup> No further investigation has yet been reported as to any effects of reserpine on the clotting mechanism.

It is noteworthy that investigators in this field have stated that *Rauwolfia serpentina* preparations are most beneficial in the young, labile, psychoneurotic patients, and are less likely to give hypotensive effects in patients having "chronic, fixed hypertension." In the latter group this drug has been advocated as a good adjunct for use with the more potent hypotensive agents; reserpine has been especially useful in these patients for the relief of symptoms, thereby giving the patients a more cheerful outlook on life.

The toxicity of *Rauwolfia serpentina* and of the alkaloid, reserpine, is apparently very low. Large doses can be given with no serious effects. In animals, a large enough dose may result in severe respiratory depression and death. However,

Table 1

SIDE EFFECTS OF RESERPINE

1. Lethargy and muscular relaxation
2. Drowsiness
3. Nasal congestion or stuffiness
4. Rhinorrhea
5. Increased frequency of bowel movements
6. Diarrhea
7. Dizziness
8. Decreased libido and potentia
9. Tendency to gain weight
10. Nightmares or disturbing dreams
11. Agitated depression
12. Dyspnea at rest

in doses used in clinical practice, no serious toxic effects have resulted. The side effects mentioned previously are frequent, but seldom severe. (See Table 1.) Many patients experience a feeling of tiredness and muscular relaxation; many have nasal stuffiness or congestion; some complain of drowsiness; some have an increase in the number of stools per day, and may even have diarrhea; an occasional patient may notice a reduction in libido and potency; and rarely a patient may have nightmares or a state of agitated depression. There are apparently no absolute contraindications to the use of this drug. It is not known if reserpine has any stimulatory effect on gastric acid secretion in man. Perhaps some caution should be exerted in its use in patients with active peptic ulcer. Although Chopra, Gupta and Mukherjee<sup>1</sup> reported in 1933 that extracts of *Rauwolfia serpentina* had a direct depressant action on the myocardium of the mammalian heart, and resulted in a slowing of heart rate and an interference of auriculo-ventricular conduction, there has been no recent evidence to support this. There have been no reports of any deleterious effects upon the myocardium or upon the conduction system in the heart in human subjects.

We have recently made a close study of 18 hypertensive patients treated with reserpine,\* with particular search for any evidence of toxic manifestations of the drug. The age range of these patients is from 31 to 59 years, with the median age being 46 and the majority of the group in their forties. Fourteen of this group were females, and four were males. Half of the group were white, and the rest Negro. Many of the patients were hospitalized for studies before institution of treatment with reserpine. Control blood pressure determinations were taken twice or four times daily for three to six days in those hospitalized. The supine blood pressure recordings taken after several minutes recumbancy in the out-patient clinic serve as all other blood pressure readings. The following studies were performed: EKG, chest x-ray (PA), IVP, blood urea nitrogen, urea clearance, 15-minute PSP excretion test, blood electrolyte determinations (sodium, potassium, chlorides and  $\text{CO}_2$ ), total serum cholesterol, hemoglobin, red blood count, white blood count, differential leukocyte count,

total serum proteins, albumin and globulin, cephalin cholesterol flocculation, thymol turbidity, bromsulfalein excretion, fasting blood sugar, urine analysis (including sugar, albumin and microscopic examination) and electroencephalogram. In all cases where possible, these studies were done before the patient had received any reserpine, and have been repeated after a minimum of seven weeks of treatment with this drug.

The dose ranged from a total daily dose of 0.4 mg. to 2 mg. This was usually divided into two, or more frequently, four doses during the day. The average patient received 0.25 mg. after each meal and at bedtime. The patients have been on reserpine for from two to seven months. Some of the patients had been on other hypotensive medications, and reserpine was used in conjunction with "Provell Maleate"\* in seven patients; these patients all had severe, chronic hypertension.

There were no significant alterations in the various studies performed which would indicate any toxic or deleterious effects of this medication. In the few months covered by this study, there was noted no decrease in the heart size as measured by x-ray; and no alteration in the renal function as measured by the PSP excretion test, urea clearance test, and concentration of urine; and there was no alteration of electrocardiographic patterns in the individual patients. The results of the electroencephalographic studies will be reported elsewhere.<sup>42</sup>

The response of the blood pressure was considered as good in nine of the group, as fair in six, and as poor or nil in three patients. (See Table 2.) Seven of this group received combined treatment with reserpine and "Provell Maleate." Of these seven, three had a good response, three had a fair response, and one had poor response. The average blood pressure change was a decrease of 29.2 mm. systolic, and 14.2 mm. diastolic; the blood pressure changes ranged from  $-59$  to  $+20$  mm. systolic, and from  $-35$  to  $+5$  mm. diastolic. (See Table 2.)

The majority of these patients had subjective improvement of their symptoms; many noted less frequent and less severe headaches, had a decrease in nervousness and anxiety, and were

\* 'Sandril' (Reserpine, Lilly)

\* 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly)

Table 2

## BLOOD PRESSURE RESPONSE OF EIGHTEEN PATIENTS ON RESERPINE

GOOD RESPONSE		FAIR RESPONSE		POOR RESPONSE	
B.P.before Tx.	B.P.after Tx.	B.P.before Tx.	B.P.after Tx.	B.P.before Tx.	B.P.after Tx.
* 200/108	130-160/70-85	* 235/120	200/105	140/100	134-160/80-100
190/110	144/90	* 200/108	172/98	180/140	190/125
192/100	120-138/70-90	180/108	149/98	* 200/120	200/125
160/110	150/90	176/100	145/100		
185/105	126/80	194/110	130-190/80-100		
* 200/120	145/85	* 218/128	185/120		
170/120	130/92				
* 180/115	135/95				
180/105	135/80				

\* indicates combined treatment with 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly) and Reserpine, Lilly.

able to sleep better than before. Two patients failed to have any subjective improvement; one of these had severe, fixed hypertension, and the other had severe emotional disturbances. Seven of these patients experienced no side effects from this drug. Twelve of the group had nasal congestion, which was of very mild degree in seven. Prior to Freis,<sup>38</sup> one of the authors (W. J. P.) independently suggested the use of an antihistamine compound in an effort to relieve the nasal congestion caused by reserpine. Many of the patients had partial or total relief of nasal stuffiness following the use of an antihistamine preparation ("Pyronil").<sup>43</sup> The great majority of patients noted a feeling of muscular relaxation and tiredness. Two had an increase in the number of bowel movements per day; one man complained of a decrease in his libido and potentia; and five patients exhibited a slight increase in body weight. In none of this group were the side effects considered serious enough to warrant stopping the drug.

It is interesting to note the change in personality, and the feeling of self-confidence that some patients on this medication develop. We have

one patient who was very apprehensive and insecure, and who was afraid to drive her own automobile out to the hospital. After several weeks of reserpine therapy she had recovered enough confidence to drive herself to the hospital for her clinic visits, and had even driven herself to distant cities.

A good example of an excellent response to reserpine may be illustrated by the following case: A 52-year-old white male insurance executive was referred to our clinic because of elevated blood pressure. He had been transferred to Indianapolis to manage a branch office of his insurance firm four years ago. With the new position came added responsibilities. His weight increased from 185 to 210 pounds. He was seen by a physician two years ago because of palpitation and nervousness, and his blood pressure was found to be moderately elevated. He was given phenobarbital,  $\frac{1}{2}$  grain four times daily, and after several weeks he was able to decrease his dosage to once daily. In the last few months of 1953, he had begun to have occipital headaches, especially in the morning upon awakening. These became more frequent and he again consulted a physician, who found his blood pressure to be elevated (190 mm. systolic). His blood

\* 'Pyronil' (Pyrrobutamine, Lilly)



pressure when first seen in our clinic was 180/109 (supine). He was admitted to our ward for studies, and a sedation test revealed a decrease in blood pressure from control values of 190/120 to 140/80 while sleeping. Other studies showed him to have essentially normal renal and cardiac function. He was treated with reserpine in dosage of 0.25 mg. three times daily. This was reduced to 0.25 mg. twice daily after one week because he complained of tiredness and dizziness upon standing up quickly. After 12 days of therapy his blood pressure was 139/89 supine and 100/75 standing. His dose was further decreased to once daily, and his blood pressure on his last visit to the clinic was 149/95 supine and 105/80 standing. He no longer complained of headaches, or of nervousness, and he appeared to be much happier than before. This, of course, represents the response of a patient with mild elevation of blood pressure and neurotic symptoms to reserpine.

Salt restriction has long been advocated as one method of treatment of hypertension. Some workers in this field have stated that the combination of a hypotensive agent with sodium restriction often has a greater hypotensive effect than either salt restriction or the medication used singly. The effect of the combined use of rigid sodium restriction and reserpine has not been mentioned in the literature. We have several patients who have been on a sodium-restricted diet plus "Carbo-Resin"\* for many months, and who have recently been given a trial of reserpine in addition to the salt restriction regimen. Preliminary observations suggest that some patients may exhibit a further lowering of blood pressure with the addition of reserpine to their therapeutic program.

Our experience with reserpine in the treatment of hypertension supports that of other investigators in this field. The greatest hypotensive effect was observed in those patients with early essential hypertension, and in those with a labile blood pressure, rapid pulse, and neurotic manifestations. However, our work also indicates that reserpine may be beneficial in the more severe forms of hypertension as an adjunct to more potent hypotensive agents, such as protoveratrine, and in combination with a salt-restriction regimen. There is much work being done

with this most interesting drug in many varied fields of medicine; and it appears that in reserpine we have a very useful addition to our therapeutic armamentarium, both in the treatment of hypertension and in the treatment of various emotional disorders.

## SUMMARY

1. A review of the history of the use of *Rauwolfia serpentina* as a medicinal agent has been made.

2. The pharmacology of *Rauwolfia serpentina*, and of its most potent single alkaloidal fraction, reserpine, has been discussed.

3. A brief review of some of the clinical studies with this drug has been given.

4. The results of our studies of the use of reserpine alone, and reserpine in combination with oral protoveratrine in the treatment of a small group of patients having hypertension have been reported.

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\* 'Carbo-Resin' (Carbacrylamine Resins, Lilly)

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# PRACTICAL ELECTROCARDIOGRAPHY\*

E. GREY DIMOND, M.D.

*Kansas City*

KEITH HAMMOND, M.D.

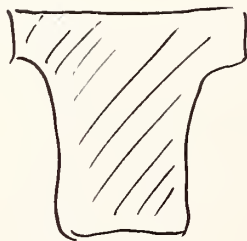
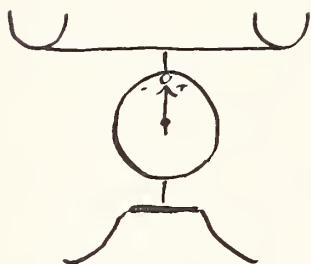
*Paoli*

\* At the 1954 meeting of the Indiana Academy of General Practice Dr. E. Grey Dimond, chairman of the Department of Medicine, University of Kansas, presented a chalk talk on "Practical Electrocardiography." Doctor Dimond has become widely recognized as a teacher of unusual ability. The lecture notes and diagrams which I present in this article, lend ample support to the acclaim which is being accorded to him. The quotation marks indicate, for the most part, the exact words of Doctor Dimond. Notes and diagrams were submitted to him for approval. It is a tribute to his pedagogy that only one or two minor changes were made.

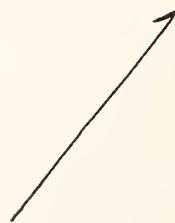
It has never before been my privilege to hear the fundamentals of such a complex subject presented in such an illuminating manner in only 50 minutes.—Keith Hammond, M.D.

## Diagram No. 1.

"I will talk about a scale, a tank of salt water, and an arrow. A scale weighs things. An electrocardiographic machine simply weighs things. When you put the electrodes in place you are just as surely measuring something as you would be if you placed your patient on a scale and had him stand there. You are measuring electrical forces of the heart."



# |

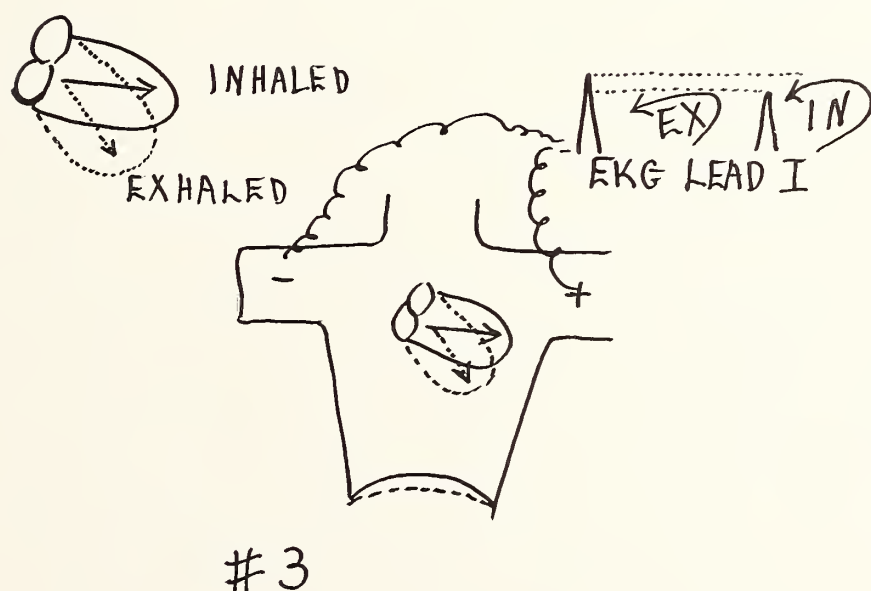
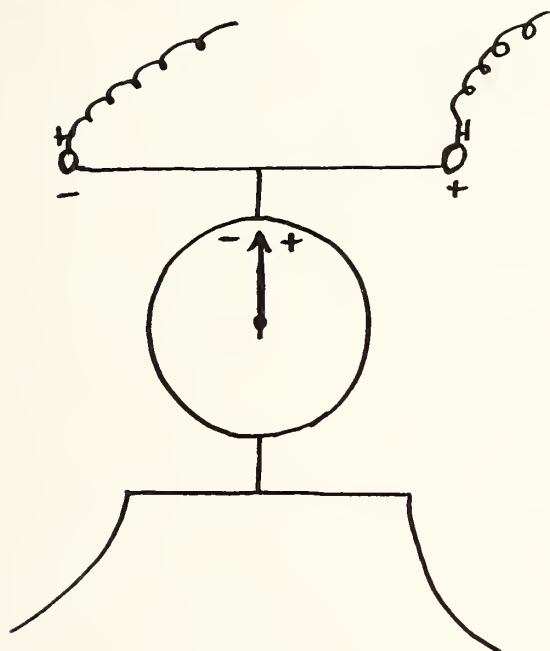


"Suppose that I place a weight of three pounds on the scale. The hand will move from zero to three. We could just as well designate this simply as a unit of three. Instead of weight, I will indicate pressure downward by an arrow. You will recognize this as a vector."

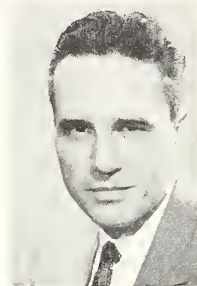


## Diagram No. 2.

"In place of the pans I will place an electrode. Now, suppose that this scale, instead of measuring forces downward, measures forces that pass back and forth between the electrodes. When you place the electrodes on a human being, you are simply placing your scale across this person's body and measuring electrical forces between these two points."



E. Grey Dimond, M.D., professor of medicine and chairman of the department at the University of Kansas School of Medicine, was one of the guest speakers at the annual meeting of the Indiana Academy of General Practice in April, 1954. His talk, illustrated by blackboard drawings, made electrocardiography seem like one of the things a GP does every day in his practice. It created much interest among the Indiana doctors who heard him. One of them, Dr. Keith Hammond, took notes throughout the talk, then went home to Paoli and made his own drawings to illustrate his interpretation of Dr. Dimond's lecture. With the approval of Dr. Dimond, *THE JOURNAL* presents notes and drawings.



Incidentally, Dr. Dimond has authored a new book, "Electrocardiography" recently published by C. V. Mosby Company, St. Louis.

## Diagram No. 3.

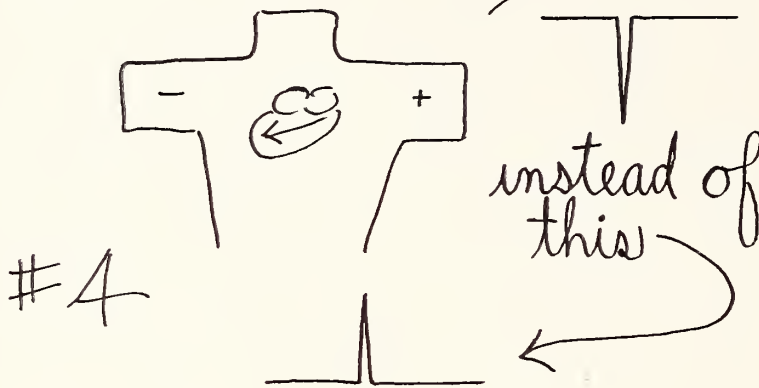
"If I put these electrodes on each side of a human body, on either side of the heart, the forces occurring in this heart will be measured by these two electrodes. Now, the arrow, with its base at the a-v node, will represent a force which will be "weighed" on our scale. You can see how the direction in which the arrow will

point will vary as this man is fat or thin. Similarly, as he breathes the arrow will flip back and forth. The more to the left the arrow points, the stronger will be the force toward the positive electrode. On our scale an upright wave will be recorded. In other words, when you see an upright wave in an electrocardiogram, electrical forces have moved toward a positive electrode."

## Diagram No. 4.

"In this example, then, it is obvious that all the electrical forces are passing away from the positive electrode (assuming that this electrode is still on the left arm). This, of course, could

*Suppose lead I looks like this*

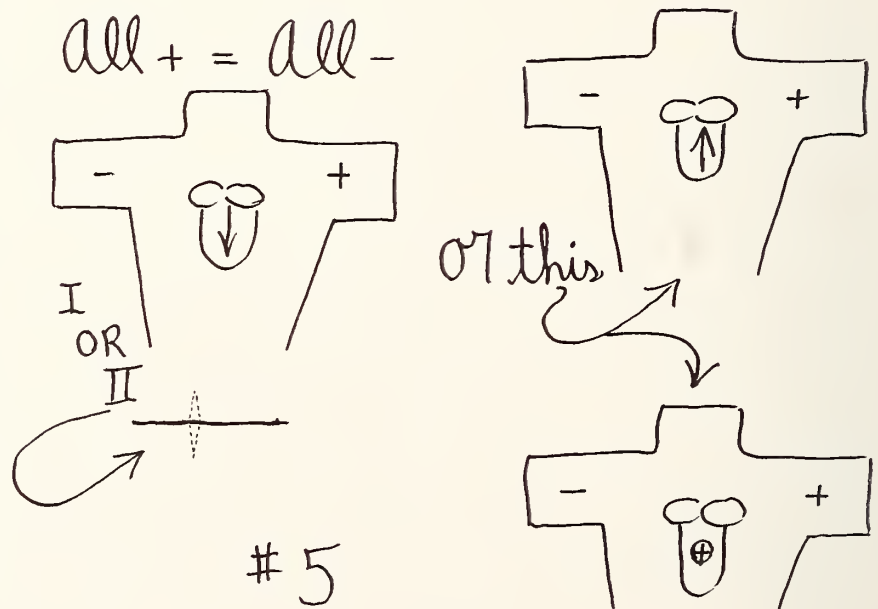


never happen in a normal human being. It could happen only, one, if the person was born with dextracardia, which is a rare bird; two, if the technician put the electrodes on backwards, which is a common bird; three, if instead of the left ventricle an enlarged right ventricle swings the electrical force around to the right."

## Diagram No. 5.

"Suppose that the electrical forces are equal in each direction. This can be true if all the force is directed downward, upward, or toward the front or rear of the chest as indicated here.

With nothing more in your hands than lead I and a recognition that this lead measures forces between the shoulders, you can already understand something of the position of the man's heart in his chest and the relative size of the ventricles."



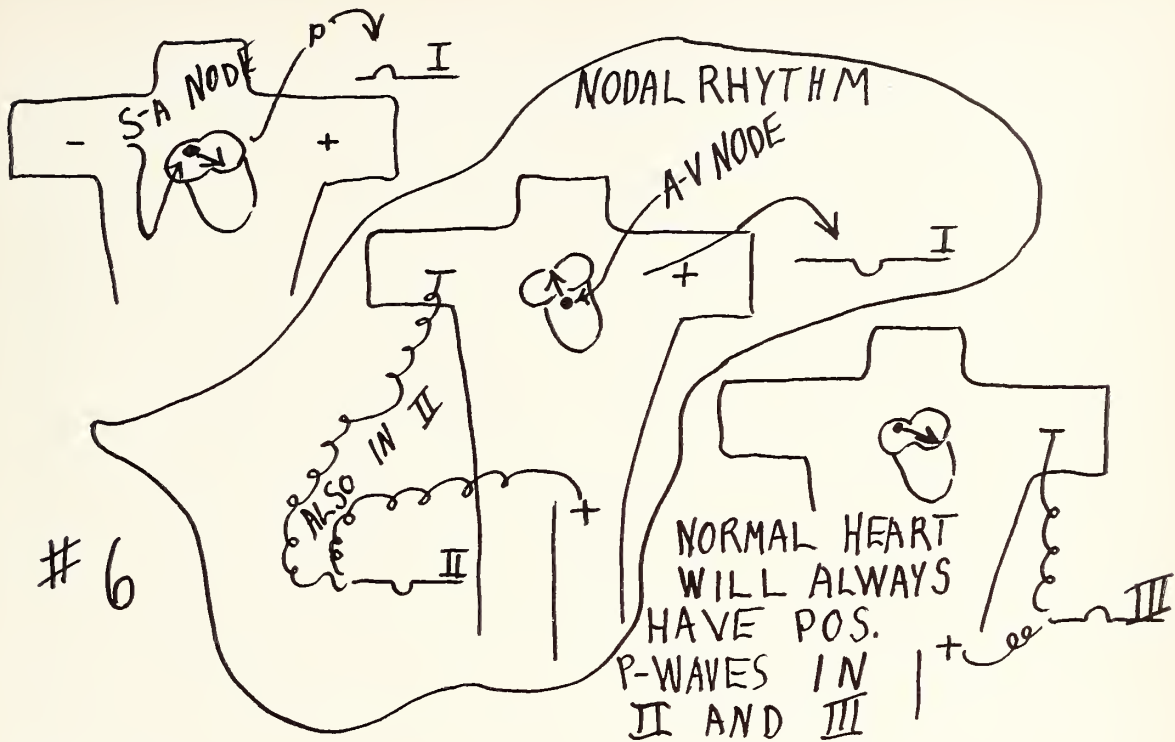


Diagram No. 6.

"This drawing shows the auricles with the sino-auricular nodes. As you can see, the wave made by the auricles in lead I will be an upright wave, since the arrow points toward the left shoulder. This is a P wave. Suppose we put the positive electrode down on the left leg. I have created another scale. Note how closely the wave made by auricular depolarization in lead I resembles that made in this new lead. This is lead II, and the arrow goes strongly toward the left leg. Now, suppose the pace-maker is moved down to the a-v node. The forces will then pass upward, strongly away from the left leg, so that you will have a markedly negative wave. This will also be true in lead I. In this way you can recognize a-v nodal rhythm."

June 8, 1954

Keith Hammond, M.D.  
Paoli  
Indiana

Dear Dr. Hammond:

I am returning your excellent drawings and description.

I am amazed at the amount of information which you were able to get out of my very brief discussion.

I have indicated a few minor suggestions. I think that the paper will need some definite introductory remarks explaining the method in which the information was obtained. I think a considerable point should be made that these are

actually your lecture notes and that what we are presenting here is simply a blackboard-chalk talk.

I have purposely not added anything to your narration, as I thought that any attempt to expand it would destroy the significance of the fact that it represents your own interpretation.

Thank you for giving me the opportunity of seeing this. As I said in the first paragraph, I am amazed at how much you were able to get out of this brief presentation.

Cordially yours,

E. GREY DIMOND, M.D.  
Professor of Medicine  
Chairman of Department



Diagram No. 7.

"The infant's heart will lie somewhat as follows because of the preponderance of the right heart. Why is this true? Because this is about the only portion of his heart which he has been using in utero. In a newborn baby, then, the electrical forces will be predominantly toward the right. His lead I will be predominantly negative or downward. As we

grow older the vector shifts over toward the left. Then, suppose we take the positive electrode and put it on the front of the patient's chest. This a V lead. The vector will point toward this electrode when it is over the right side of the chest of a newborn, but later on, when the left ventricle becomes predominant, the vector will point away from this same electrode."

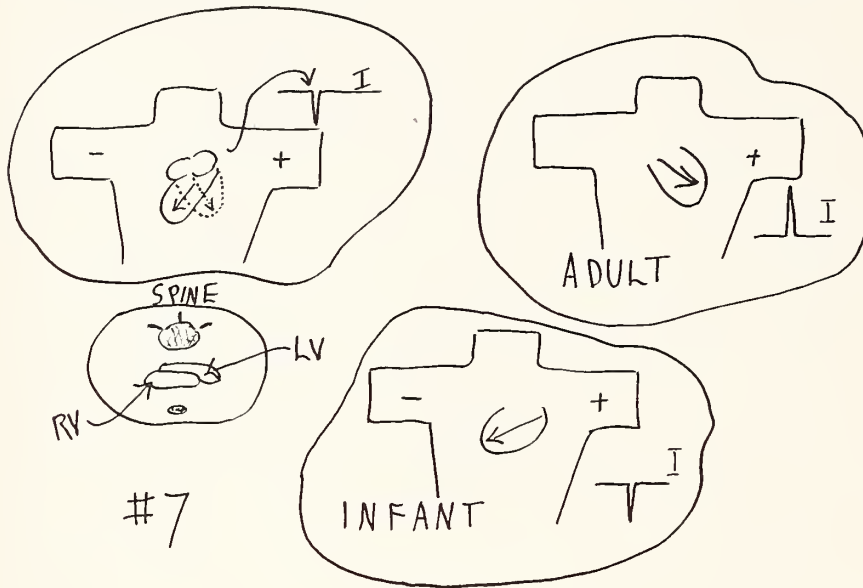
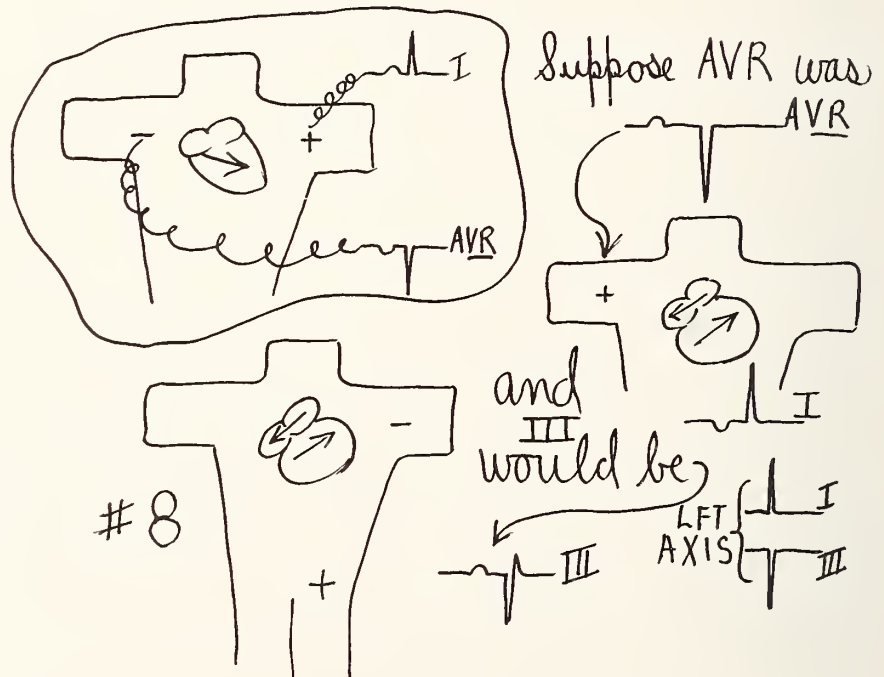


Diagram No. 8.

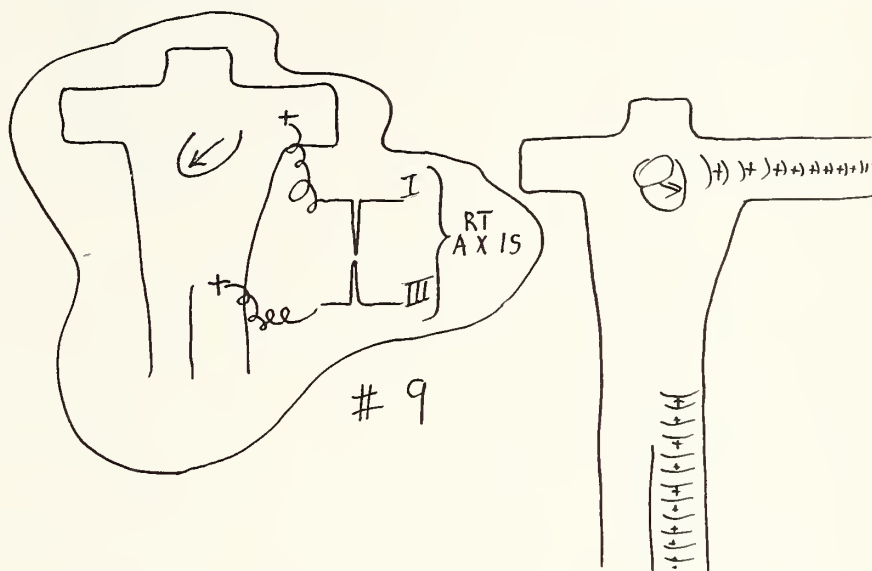
"In lead aVR the V means you are measuring voltage. The R indicates that the voltage you are measuring is at the right arm. You can see, then, how you can reconstruct the tracing if you know where the vector points. Suppose that the left ventricle is so large that it simply takes over the electrical depolarization of the heart. Lead III will be predominantly downward and lead I will be markedly upward, and we have what is recognized as left axis deviation."



## Diagram No. 9.

"The first portion of this diagram represents the manner in which one predicts the configuration of leads I and III in right axis deviation where there is 'toe in' as contrasted to left axis deviation where there is 'toe out.'

"From this diagram (the second portion) you can see how it makes no difference where you put the electrode on an extremity. In other words, the human body is comparable, as an electrical conductor, to a tank of salt water."



## Diagram No. 10.

"In the normal heart a stimulus which is started from above passes down through the conduction bundles in a rapid manner. This causes a synchronous contraction of the ventricles, which normally happens in just .1 second. Suppose this man's heart develops a disease which prevents one ventricle from getting its stimulus. This is a bundle branch block. His two ventricles will not be stimulated synchronously. This will widen his QRS complex. The ventricle on the unaffected side will get stimulated first. Then, when it contracts, the stimulus will be carried to the opposite side through these contracting muscle fibers themselves rather than

through the normal conduction system. Consequently this opposite side, the affected side, will contract only after some delay. The vectors will then point as indicated, widen the QRS complex, and deform it by a delay on the affected side. How do you know which bundle had the block? Simply pick up your six V leads and see which one had the delay in the QRS reaching its peak positive amplitude."

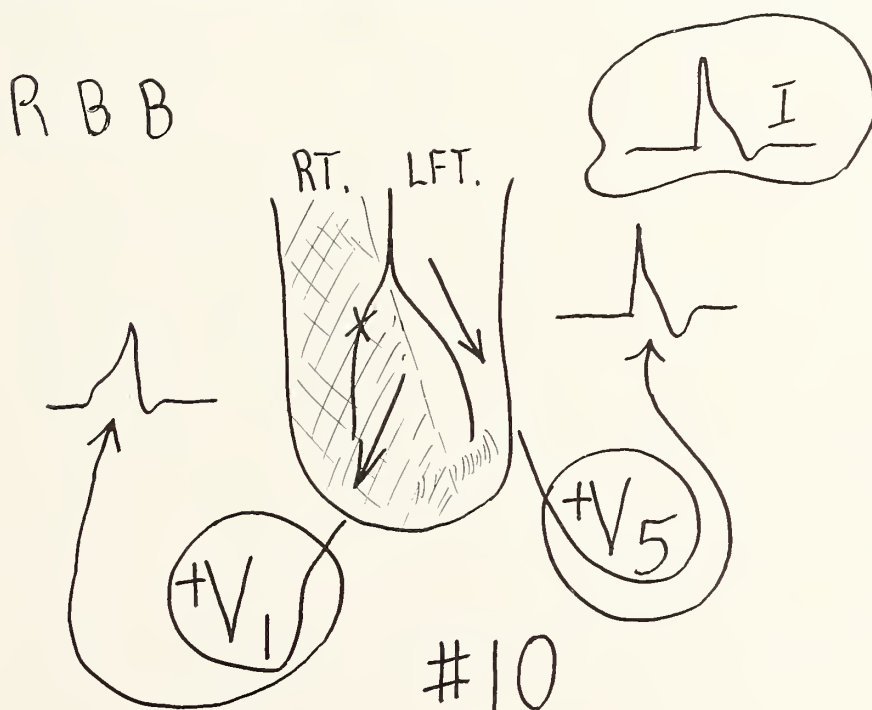
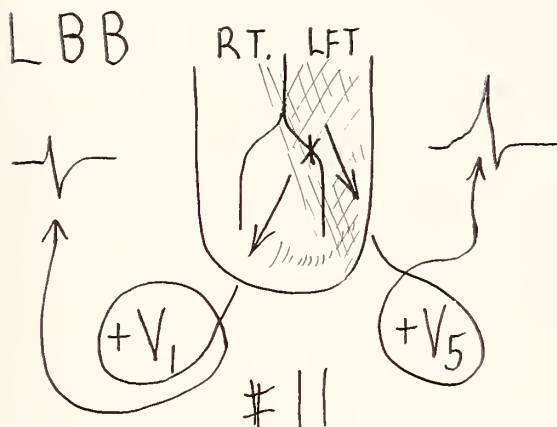


Diagram No. 11.

"In this case the left bundle is blocked. The direction of the delayed vector toward the electrode on the left is toward this electrode, and the direction of the vector in the unaffected portion of the heart is away from this electrode."



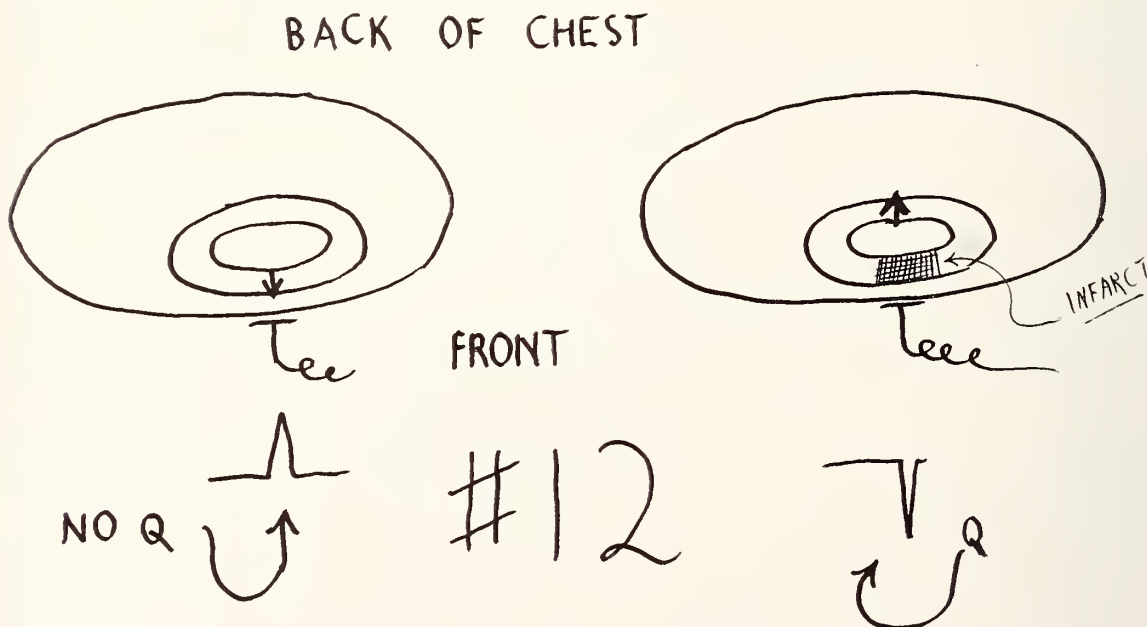
Keith Hammond, M.D., Paoli general practitioner, was so impressed by the clarity of the chalk-talk given by Dr. Grey Dimond before the Indiana Academy of General Practice that he tried his own hand at illustrating the notes he took as Dr. Dimond spoke. Results are presented with his notes, which quote liberally from the original talk.

Dr. Hammond got his degree from I.U. School of Medicine in 1938, interned at Marine and Charity Hospital, New Orleans and at Maternity Center, Chicago. Because he was a native of southern Indiana he knew the need for good rural doctors, so went to Paoli to do general practice. Except for three and a half years in the U.S. Army during World War II, he's been there since. Dr. Hammond is married and the father of four boys and a girl. He's been a member of I.A.G.P. since it was organized and is now district Connelior.

Dr. Hammond has had two papers published in GP, one of which was reworked for Parade, the Sunday magazine supplement.

Diagram No. 12.

"Suppose we put a positive electrode on the front of the chest over the left ventricle. When that ventricle was healthy a vector came out toward this electrode. An upward wave is recorded. Suppose the patient loses a portion of the muscle in this ventricle—it dies. Then that same electrode will not have a vector coming toward it. Instead, the rest of the musculature depolarizes away from the electrode. Consequently, that electrode is looking at the tail end of a vector. That electrode will then record a negative wave, which is what you look for in coronary occlusion. You look for negative waves. You call them Q waves."





# TREATMENT OF THE MENOPAUSE WITH A LONG-ACTING ESTROGEN, TACE\*

B. E. EDWARDS, M.D.

*South Bend*

**F**ROM THE EARLY DAYS of clinical medicine, the control of symptoms of the female climacteric has proved a vexing problem to the physician. Although the primary disorder is ovarian failure, the clinical picture thereby produced has superimposed upon it the variegated imprints of many socio-economic and emotional factors, and it is often difficult to separate the component parts. Indeed complete differentiation is often impossible and it is therefore not surprising that therapy of the menopausal syndrome has included psychotherapy, sedation and hormone replacement, either singly or in combination.

It is generally accepted that estrogen therapy is not necessary in all cases but there are significant numbers of patients whose symptoms cannot be relieved by any other means.<sup>1</sup> In these the ordinary types of estrogens produce relief but their use is often accompanied by certain limitations. In order to produce prolongation of estrogenic effect, parenteral administration has become common practice and this is, in many cases, an economic hardship for the patient. The oral administration of estrogens has been attended by a relatively high incidence of gastro-intestinal upsets and has been followed by the frequent occurrence of withdrawal bleeding, sometimes of alarming proportions. Short-acting estrogens have the additional disadvantage of being eliminated rapidly from the body and as a result the autonomic nervous system adjusts only with great difficulty to the widely fluctuating estrogen levels. Not uncommonly estrogens have been administered for years to patients in whom prompt return of menopausal symptoms

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has almost invariably followed the sudden cessation of therapy.

A new synthetic estrogen, TACE\* (chlorotrianisene), which possesses unique characteristics has recently become available. Laboratory studies<sup>2</sup> have demonstrated that chlorotrianisene, like other estrogens, causes estrogenic changes in the mammary gland, uterus, and vagina. Unlike other estrogens, it does not cause pituitary enlargement and there is little or no adrenal enlargement in the laboratory rat.<sup>3</sup>

## ADVANTAGES

In laboratory animals, following either oral or subcutaneous administration of chlorotrianisene, a long duration of estrogenic activity was produced<sup>2</sup> and this was demonstrated to be due to the storage of estrogenic material in the body fat from which it was released slowly over fairly long periods.<sup>2</sup> Estrogenic activity in human fat following oral administration of chlorotrianisene has also been reported.<sup>3</sup>

Since chlorotrianisene appeared to have clear-cut advantages which would overcome many of

\*TACE is the trademark of The Wm. S. Merrell Company, Cincinnati, Ohio, for its brand of chlorotrianisene (tri-p-anisylchloroethylene).

the shortcomings of usual estrogen therapy, a clinical evaluation of its potentialities was begun over one year ago. The clinical results have been excellent and the theoretical advantages have been demonstrated to be real.

Chlorotrianisene was administered to 33 consecutive patients with symptoms due either to surgical or natural causes. Their ages ranged from 29 to 50 years and the syndromes presented were of varying degrees of severity. Early in the study various dosage regimes were investigated and although it was determined that doses as low as 6 mg. per day were effective in a significant number of patients, daily doses of 12 mg. to 24 mg. were ideal. Treatment was continued until complete relief was obtained or until it was obvious that this was not likely to occur. The period of administration thus varied from 3 to 20 weeks and in general averaged about two months. Some of the patients had previously received other estrogens, both oral and parenteral, and it was thus possible to compare clinical response in the same patient. In this series the hot flush, nervousness and formication were considered to be the most significant symptoms and the partial or complete relief of these complaints was used to evaluate the efficacy of the treatment. Complete relief was not recorded unless all formication had disappeared, as this usually was the last symptom to linger. In addition, a voluntary verbalization of a feeling of well-being was considered essential before complete benefit was said to have occurred.

On initial examination of the records it was found that complete relief of symptoms had occurred in 24 (73 percent) of the patients, while 9 (27 percent) had had unsatisfactory results. Therapeutic results usually occurred within 5 to 7 days after the beginning of treatment and were well-established by the tenth day. Of the 9 patients in the unsatisfactory group 5 were definitely psychoneurotic and were referred for psychiatric treatment. Three of those who had poor results from the administration of chlorotrianisene suffered concomitantly from rheumatoid arthritis and it has been our experience that menopausal patients with rheumatoid arthritis are notoriously difficult to treat. One

therapeutic failure was in an entirely non-operative individual. If the 3 patients with rheumatoid arthritis and the 5 psychoneurotics be removed from the series the adjusted satisfactory "complete relief" figure is 96 percent.

Prolonged relief, presumably due to the presence of estrogenic activity in the fat following administration of chlorotrianisene, was noted in this series. The shortest time of recurrence of symptoms after treatment was 2 weeks (2 cases) and the longest duration of relief was 6 months (1 case). The average duration of relief was 4 months.

There was only 1 case of withdrawal bleeding in the entire group and this occurred in an extremely thin 98 lb. individual in whom fat storage was unlikely. Urticarial reactions of a mild nature developed in 3 cases. No gastrointestinal disturbances were noted.

## SUMMARY

A small series of menopausal patients has been treated with a new type of estrogen, chlorotrianisene, which has a depot-like action following oral administration. Complete relief of symptoms occurred in 96 percent of the cases treated. Side-effects were minimal and the drug was well tolerated. Because of the long duration of estrogenic activity following chlorotrianisene it has been possible to control menopausal symptoms with intermittent rather than continuous treatment.

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## OFFICE GYNECOLOGY

### Some Practical Methods of Treatment

J. W. VISHER, M.D.

*Evansville*

**D**URING the last 25 years in the treatment of pelvic disorders in women, I have learned much from reading scores of articles and several books, but more from experience. In this paper, no attempt will be made to review the literature, or to cover the whole field, which would require a book. Instead, I will briefly discuss some practical points which may be helpful to others facing the same problems.

In vaginal examinations it is important to have a good light and three or four sizes of bivalve specula. The two smallest are for virgins and nullipara, one small and short, and one long and narrow. The medium speculum is best for the great majority of women, but occasionally in a multipara with a cystocele and rectocele, it is impossible to see the cervix without the largest size. This size is also helpful when coagulating the cervix, or when obtaining biopsies or doing Rubin tests.

Another useful gadget is a small hand mirror, such as women carry in their purses, to show the patient the abnormal conditions found. She should hold the mirror slightly diagonal above her vulva so as not to obstruct the light, and she lifts her head from the pillow and, of course, looks at the mirror while the examiner points to the cervix with an applicator. Seeing is believing, and the two minutes it takes to help her to look at her own caruncle or diseased cervix is time well spent. She is much more likely to consent to necessary treatment after such a demonstration. Weeks later, when the pathology is corrected, another mirror demonstration is good practice.

Another valuable, frequently neglected procedure is digital examination, with the patient standing. She bears her weight on her right foot and places her left foot on a low platform, while the examiner sits facing her right hip and exam-

ines with his right index finger while she strains, for uterine prolapse, cystocele, rectocele, uterine tenderness and retroversion. The diagnosis of third-degree retroversion while the patient is lying down is often erroneous, since frequently when she stands the uterus rises into a more vertical position. When it is really seriously retroverted, it descends still farther backward and downward with the patient standing, and backache and bearing-down sensations may result.

#### SUPERFICIAL INFECTIONS

In the realm of therapy, perhaps the most frequent complaint is of vaginal discharge, with vulvar irritation and itching. Examination usually discloses an infected cervix with secondary vaginitis, but sometimes the cervix is normal and there may or may not be pus in the vagina. When pus is found, a drop of it is mixed with normal saline solution on a slide and examined microscopically at once for trichomonads. When these are absent, monilial infestation is suspected, which produces a characteristic granular, cheesy discharge, often without leukocytes, but with severe irritation of the vaginal walls and vulva. In the postmenopausal woman, atrophic vaginitis is quite common, which may or may not cause symptoms.

Superficial cervical infections in late adolescence and in nulliparous women in the early twenties usually respond to weekly treatments with 10% silver nitrate solution. In more mature women and in those with children, the infection is deeper and should be treated with electrocoagulation or cautery.

Trichomonas vaginitis usually responds quite well to prolonged use of carbarsone suppositories (Lilly) or westhiazole applications (Westwood), but recurrences are common unless foci in the



cervix and Skene's glands are eradicated. Monilial vaginitis responds nicely to propion jel (Wyeth). Purulent postmenopausal or postpartum or postoperative nonspecific vaginitis often is helped by argypulvis (Barnes) or premarin creme (Ayerst).

In other patients who complain of discharge and irritation, no discharge is found upon examination, but instead the walls of the vagina are dry and irritated. Upon questioning these women usually admit that they take daily douches. When this pernicious habit is stopped, they are promptly relieved. I tell them that douches are harmful, as they wash away Döderlein's bacilli, which keep it free from infection.

Still another cause of vulvar irritation is the use of perfumed and medicated soaps, especially dial. Occasionally a severe vulvar irritation is caused by wearing new, unwashed panties. The patient is sensitive to dye or other chemicals used in their manufacture.

Warm boric acid packs applied to the inflamed vulva and antihistamine orally are helpful. Sitz baths with hot water containing a half cup sodium bicarbonate to a quarter tub of water are comforting. Nupercainal (Ciba) or other anesthetic ointment may be used cautiously for a short time, but allergic dermatitis may develop, which makes the patient worse, so I seldom order it.

Many patients complain of painful or unsatisfactory intercourse, which calls for a very careful history and examination. In most cases dyspareunia is due to marked tenderness of the uterus, usually caused by chronic cervicitis, and is relieved following cauterization. Adnexal disease, fibroids or urethral caruncles are less frequently to blame. In others, too frequent intercourse or faulty technic is responsible. In these cases it is important to talk to the husband, and if this is not possible, to supply the patient with a manual on sex for them both to study.

Marital unhappiness usually begins in the bedroom, which makes premarital examination and advice wise, but in my experience it is seldom requested. More often they come after the first few weeks of unsuccessful marriage caused by a tight hymen or acute bride's cystitis. At first some couples are well adjusted sexually, but later, if the husband drinks and abuses his wife, or fails to provide, she loses her libido for him.

Men and women are both often selfish and do not consider the sexual requirements of their partners. Some men demand sexual relations much too frequently, while some women prefer total abstinence. I explain to them that the seminal vesicles are continually secreting semen and that they need to be emptied at regular intervals. Before marriage this is done by nocturnal emissions or wet dreams. After marriage these no longer occur and regular intercourse is necessary to prevent restless nights and discontent. A good plan is to have the husband and wife agree on certain nights for marital relations and both will plan accordingly.

In a small minority of women, poor libido is psychological in origin. It may respond to suggestion and superficial psychotherapy, but more often it is incurable, except perhaps by psychoanalysis. However, if they love their husbands, and intercourse is not actually painful, they usually get along fairly well without orgasms.

## STERILITY

Another important problem is sterility. Here again the most frequent cause is chronic cervicitis, with a thick, tenacious plug of mucopurulent secretion obstructing the cervix. Another frequent cause is few or no sperms in the husband's semen. I request a thorough physical examination and a semen specimen in every case before subjecting the woman to extensive examinations or treatments. I tell the husband to withdraw and ejaculate into a small, clean cold cream jar, instead of using a condom, since the powder on condoms is spermicidal. I examine the semen carefully for motility, abnormal sperms and number of sperms. It is surprising how many healthy men have few or no sperms. They should be treated by thyroid extract, wheat germ oil and avoidance of tobacco, which is sometimes successful.

Much more satisfactory is the treatment of the woman by repeated Rubin tests when the cervix is again healthy. My modification of the Rubin test requires very little equipment and is safer than the introduction of a large amount of gas under pressure. I cleanse the healthy cervix carefully and apply cocaine crystals to the canal for a few minutes. I then paint the cervix with tincture of merthiolate 1:1000 (Lilly), grasp it with a sterile tenaculum and carefully dilate it to

the size of the Rubin canula. I then pass the canula tip through the cervical canal and inject with a sterile, wet Luer syringe 10 cc. of air through the canula into the uterine cavity. Care is taken not to use too much force or cause more than a little pain. An assistant or nurse places the bell of a stethoscope over each tubo-ovarian region and listens for bubbling sounds. It is important to differentiate the noise caused by reflux of the air around the canula in the cervix. If this occurs, I readjust the position of the canula and the amount of pressure. If air does not go through the tubes at first, several syringes full of air should be injected, of course, leaving the canula open between each injection, and often the tubes will eventually open. If injections are unsuccessful at one sitting, additional attempts should be made at weekly or longer intervals, since later trials are often successful unless the tubes are organically obstructed. Wheat germ oil, small doses of thyroid extract and iron for anemia are also ordered and advice is given concerning frequent intercourse at the time of ovulation.

I have no statistics to prove my results, but many pregnancies have followed the above regime and the parents are very grateful.

So much has been written about hormone therapy that the reader becomes confused and does not know what drug to use to help his patient. My most frequent medication is estrogen (estromone) (Endo) in oil or water by intramuscular injection, in 20,000-unit dosage once a week or as needed to control menopausal symptoms. When the patient feels better, I often switch to tylosterone (Lilly) an androgen and estrogen tablet for oral use once daily.

In functional menorrhagia, premenstrual tension, mastalgia and in mild cases of endometriosis, testosterone (Lilly) injections are often very helpful. After the acute symptoms subside, medandren linguets (Ciba) may do the work.

Pranone (Schering) in 10 Mg. tablets (oral

progesterone) three times daily during menses may also be helpful in functional menorrhagia. If hormone therapy fails and anemia is severe, I advise dilation and curettage and blood transfusions, which usually decreases the menses for many months or permanently. The pathologist often finds polypoid endometritis, but sometimes retained secundines from an unrecognized early incomplete abortion.

## SUMMARY

In conclusion, I wish again to emphasize the frequency and importance of chronic cervicitis. Perhaps 40% of adult females have cervical pathology causing symptoms, such as vaginal discharge, bladder irritation, backache, tubo-ovarian pains, nervousness, easy fatigueability, excessive menses with anemia and dyspareunia. Furthermore, cervical carcinoma usually starts in an infected cervix, and I have never seen or heard of one starting in a cervix which has been properly treated by cautery or electrocoagulation. Of course, cauterization will not cure a cancer unless it is very small indeed, so I obtain a biopsy in the office on all suspicious cervixes before electrical treatment. This can be done without much pain if cocaine crystals are applied beforehand, and the bleeding can be controlled by electrocoagulation.

Many women who come to me with a bad cervix and a tender uterus, have already had their tubes and one or both of their ovaries removed, and others have had their uterus removed supracervically without relief. Proper treatment of the cervix would, in many cases, have made major surgery unnecessary and would have preserved their child-bearing function.

Finally, I advise my patients after recovery of their health to return every six months for a complete physical examination to determine the permanence of their recovery and for follow-up treatments when indicated.

# FOETUS COMPRESSUS

## A Case Report

E. R. APPLE, M.D.

*Salem*

THE FOLLOWING is a case report involving the death in utero, flattening, and mummification of a fetus of four months gestation with survival of the remaining twin. This represents a rarity in the mechanisms of intrauterine fetal development. I have not examined the literature sufficiently to know the frequency of these conditions, but I feel sure it must be a most rare happening.

The patient, a 29 year old white para IV, gravida VI, presented herself in my office on March 9, 1954, desiring prenatal care and reservations for delivery.

Her past obstetrical history consisted of four previous normal full-term deliveries in years 1946, 1949, 1951, 1953. She aborted a fetus of approximately 3 months gestation in 1948. The first three were home deliveries and all infants weighed approximately seven pounds at birth. The last delivery was performed by me at the Washington County Memorial Hospital in Salem, Indiana on March 4, 1953. This infant's birth weight was seven pounds two ounces. Approximately one month before that delivery the patient presented herself in my office for care. At that time her serology was returned doubtful by the Kolmer method and negative by the Mazzini. A repeat returned the same. However the cord blood obtained at delivery was negative by both tests.

Her prenatal course pertaining to the initiation of this paper had been normal. Her last menstrual period was August 4, 1953, making her expected date of confinement May 11, 1954. There was no excessive weight gain; her serology was negative this time to both tests; her RH was positive; the only complaint was mild heart burn. On April 8, 1954 the patient went

into spontaneous premature labor and delivered a normal five pound seven ounce living female. With pressure on the fundus a second fetus was expressed along with the placenta and membranes. This female fetus was dead, flattened, and smeared with a yellow-white thick "cheesy" material. The skin was not macerated but was tough, thick and leathery. The skin had almost normal color; the infant fetus measured approximately twenty centimeters in length. It was attached by a very small cord to the same placenta as the normal infant and had its own amniotic sac. The placental vessels to the small cord were atrophic and the vessels to the small cord covered much less surface area than those larger vessels supplying the normal cord. The maternal surface of the common placenta appeared normal. The weight of the dwarfed fetus was not ascertained. After photos were made the complete specimen (shown in





picture) was placed in the County Hospital Laboratory where it remains now in preservatives. The mother and baby were discharged after an uneventful three day hospital stay and at present are doing well.

### COMMENTS

The preceding case demonstrates the old law of "the survival of the fittest." It represents a condition in which there is a development of a dual blood supply from one placenta with an anastomosis of the circulation of the two fetuses in the common placenta. As may happen in these

cases, fetus #1 had the most ample blood supply since the placenta vessels to its cord covered the greater surface of the placenta. Fetus #2 fell prey to the more abundant blood supply and resulting nourishment of fetus #1, ending in death. In this case death was late enough in gestation that the fetal parts had already developed. The condition above resulted in a flattening of the fetus against the uterine wall by the growing twin with the development of what is termed a "Foetus Compressus." The mummification of the fetus resulted in the non-macerated fetus.

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### An Abstract:

#### THE HEART AND GALL BLADDER DISEASE

The authors use numerous references to literature plus a series of their own cases to support the long established impression of a relationship between gall bladder disease and heart disease. This conclusion is drawn from the observation that cardiac arrhythmias, conduction defects, abnormalities in the electrocardiogram and anginal pain frequently disappear following cholecystectomy in cases of known cholecystitis.

They further cite evidence that many of the above mentioned states are reversibly produced by distention of the common duct through a T-tube. The presence of overlapping courses of the afferent nerves from the gall bladder and the heart is reviewed. They further emphasize the increased hazard in gall bladder surgery in the patient with real heart disease and also the fact that occasionally the gall bladder patient will present with primary cardiac symptoms.

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# The *Journal*

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## GENERAL PRACTICE ISSUE

**T**HIS SPECIAL ISSUE of THE JOURNAL is published as a tribute to the general practitioners of Indiana. The articles have been designed and selected to be of interest and practical value to those in general practice. Most of the editorial work on this number has

been accomplished by the officers and members of the Section on General Practice. The staff of THE JOURNAL takes pleasure in acknowledging this assistance and wishes to express appreciation for the interest which the officers of the Section have taken in the undertaking.

## THEN AND NOW IN GENERAL PRACTICE

The "then" I refer to was on May 26, 1908 when the Dean of Central College of Physicians and Surgeons, which was affiliated with Indiana University, told us that on the next morning we would journey to Bloomington, Indiana and receive our diplomas for the four years work we had just completed.

When we entered medical school it was required that we be graduates of a four year course in a commissioned high school. Most of the men of my class had been township

school teachers and had taught from at least three up to ten years. To help our financial situation we had worked at something else during school vacations. I personally had waited tables in a boarding house for meals and was a general flunky for my bed.

Now the men who enter medical school still have to be graduates of commissioned high schools but must have a B.S. degree, a B.A. degree, or some better preparation, in addition. They also do four years didactic work and spend

one to five years in hospital work as intern, resident, or special resident, if specialization is sought.

We of the older school usually began with some older physician who had worn himself out working night and day to care for those who needed relief. Of course we had better preparation than the doctor of a generation before us, but we had no internships like the doctors of today hold. We have recently advocated a preceptorship of six weeks between junior and senior years. Many states have agreed to this and the University of Kansas School of Medicine makes preceptorships compulsory.

In our own state of Indiana a number of senior medical students are asking for such training under general practice men so they may become the excellent family doctors of the future. Scholarships also are given to men in our medical schools to help them take an extra year of general practice residency so they will be better prepared to do the work they have chosen. Our educational system has advanced greatly.

Our armamentarium then was limited to a few staple items. Few, if any, drugs were prescribed; ambulances were unheard of; and only two trains were available, one into and one out of the city each day. These were indeed horse and buggy days. In my first 15 years of practice perhaps 20 to 25 men were induced to come to my home town to give me help as consultants, but upon the advent of motor vehicles this changed.

Now we are faced by an entirely different situation—antibiotics, sulfa, et cetera; we are also including atomic fission material.

Our biggest problem today is to see and treat about 80 percent of all illnesses and keep up with the progress and research in the field of general practice at the same time.

In Indiana the Academy of General Practice now has at least six meetings each year in different parts of the state so that as many physicians as possible may take refresher courses in the many phases of the general practice of medicine. The physicians of a particular district may ask for the kind of a program they are especially interested in such as heart, blood pressure, gynecology, pediatrics, etc., and it will be given by the best talent available. A certain

**O. T. Seamahorn, M.D., Pittsboro,** is president of the Indiana Academy of General Practice. He's had a long career in organizational work in Indiana State Medical Association—Seventh District Councilor, chairman of the Section on Medicine, a member of the Committee on Public Policy and Legislation for 16 years and its chairman 3 years. In his editorial he discloses a firm belief in "keeping up with medicine" and in sharing the work load in medical organizations.



number of post graduate hours is granted to the physician for attendance at such a course; called credit hours.

Perhaps many of you would like to know what we mean when we say "general practice." The best definition of it that I have ever heard was one given by Dr. Fred B. Campbell, President Elect of the Massachusetts chapter of General Practice. He said, "a general practitioner is a doctor who looks at his patient in many ways and with many eyes. He regards him with the eyes of a physician, surgeon, psychiatrist, and in all other specialized ways as well as in some ways that are not clearly defined. He is at times a financial backer and advisor in economic things; he is a moral support for some who have weakness of character or personality and also is a father confessor to many. He is a guide throughout life; bringing the infant into and safely through life. He guides the old and seriously ill out of this vale of tears in an easy and in as gracious a manner as possible. He cannot also measure his success in money, but rather in the good esteem he is held in by the minds of those for whom he has worked so earnestly to serve." This, my friends, is the true purpose of every family doctor who does general practicing.

I have wondered why all men who do general practice do not want to improve their knowledge and ability. If asked as to why they are not interested in improvement one would say that he had no need for same; another would say he had as many patients as he could care for now and did not want any more because his success was of his own personal individual effort and that the A.M.A. or the A.A.G.P. had never done anything for him; but he paid



his dues just the same to keep himself on the roster of membership. *He* always gives you to understand that he attended the church, lodge, Lions Club, and Chamber of Commerce meetings to keep up with community affairs, though. Which is more important?

Some would resent the fact that they must keep up with our educational requirements because they were the best students in their classes; yes, classes held some 20 years ago. They just don't want their patients to know they should go back to school to keep up with the advancement of medical knowledge. Last but not least, there are a few who stand up on the sidelines and say "when you have improved the hospital and medical privileges we will join you" not even caring for the fact

that we are now struggling to build higher standards for private and public health and are trying to better the relationship between the general practitioner and his community—and his country.

The cost of medical care could be decreased if all of the people understood that they should have a family doctor. The specialist is very essential but over-specialization has proved detrimental.

I think we must accept and vigorously push the idea that every physician and his family should have a family physician, and that every family in America should have a personal family physician.

O. T. Scamahorn, M.D.  
Pittsboro

## PRECEPTORSHIP TRAINING IN INDIANA

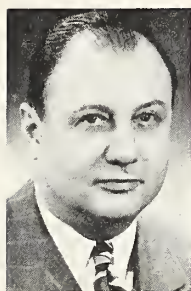
*P*RECEPTORSHIP TRAINING for senior medical students is established at the Indiana University School of Medicine on a voluntary basis for all qualified senior medical students. At the present time more than 50 doctors, members of the Indiana State Medical Association, have volunteered to serve as preceptors. These doctors are to be congratulated and commended for their effort not only to offer their time and desire to be of service, but also by providing living quarters, room and board, to these new members of our profession.

The preceptorship plan permits the student to accept responsibility. In the medical school, the staff, the residents, the interns, absorb responsibility before it can sift through to the student. As a result, doctors often claim they feel insecure when they first enter practice—don't know their limitations—can't recognize the point where consultation and/or referral may be called for.

The preceptor, for his part, can specifically help the student learn about general practice by permitting him to observe closely (most patients don't object if the student's status is explained), and by discussing the case and its implications with him after the examination the preceptor can help the student understand the rationale

of treating common ailments—colds, headaches, backaches, boils, et cetera—and, as mutual confidence is established, can permit the student to diagnose and propose treatment. The preceptor can further help the student with practical details—methods of greeting patients, of questioning, listening, examining, and discussing fees. He can bolster the student's ego by calling him "doctor" and can create a friendly, warm atmosphere so that the student will gradually come to feel free to offer opinions.

Dr. Louis H. Weiner of Philadelphia, a member of the commission on education of the American Academy of General Practice states: "Acting as preceptor is one of the best ways the busy general practitioner can find to contribute toward medical education and take an active part in the medical schools' teaching programs. Under a preceptor plan for medical students, general practitioners have an opportunity to provide supervised experience to the student that could not be obtained in any other program in the medical school. A general practitioner can demonstrate the proper relationship between doctor and patient. He can show the student how to set up and operate a private practice office. In general, the student can acquire confidence in the handling of patients



Since returning from service in the U.S. Navy during World War II Lester D. Bibler, M.D., Indianapolis, has taken an active part in both I.S.M.A. and I.A.G.P. As chairman of the Sub-Committee on Preceptorships he is working to find a plan which will narrow the gap between school and actual practice. He tells here of the groundwork which has been laid to make Indiana's plan practical.

Dr. Bibler was recently named delegate from the General Practice Section to A.M.A.'s House of Delegates.

and in the running of a medical practice, so that he can later set up his own practice more advantageously."

Last of all, the preceptor should not encourage the student to cut his hospital training short and hurry back to him after graduation. Every student should be aware of the perils of active practice after only one year of hospital training. It is no accident that the American Academy of General Practice endorses a general practice residency. The field is a complex one and requires plenty of preparation.

It is of particular interest to note there has been very little, if any, criticism to preceptorship training even in medical schools, where it is a required subject during the senior year.

Numerous complimentary remarks have been made by various preceptees. James B. Ifwerstrain, a senior medical student of the University

of Arkansas School of Medicine who is a preceptee under Dr. Lowery McDaniel of Tyronza, Arkansas, states: "I think it is a wonderful experience. Medical school instruction is on an assembly line basis. There is a different environment and the patient-physician relationship is emphasized in preceptorship training." The University of Arkansas has compulsory preceptorship training for an eight weeks period. The preceptees are assigned to the preceptor and there is whole-hearted support by both the medical student and doctor of medicine in the State of Arkansas.

Comments by other medical students are equally enthusiastic, many of them stating that preceptorship experience provides a more practical realization of the practice of medicine. Their concept of medical economics is on a more practical pattern. A more wholesome concept of patient-physician relationship is provided in a more practical manner than is possible in the present type of medical training.

A few pilot plans on a voluntary basis are being arranged under the direction of Dr. E. W. Shrigley, of the Indiana University School of Medicine and it is hoped that with the cooperation of medical students and doctors in Indiana this type of training will become part of the practical phase of instruction of our future doctors of medicine.

Lester D. Bibler, M.D.  
Indianapolis

## IN DEFENSE OF HOVERING

WE HAVE just learned a new word. We are told that when a family physician sends a patient to the hospital under another doctor's care, and then keeps going in to see his patient, that is called "hovering." There is thought to be something underhanded or indecent about hovering, something like splitting fees. For that reason it is a term of derogation. The derogation is by the staff member, or perhaps specialist, who now has the patient, and resents what he considers interference. Certainly not by the patient, who would be disappointed and resentful if his own doctor didn't show up fairly regularly. Certainly not by the family physician.

The implication by those who sneer at hovering is that the family physician is going to send the patient a bill for dropping in to see him and doing nothing. If this should happen, his bill and the specialist's would collide, and sparks fly.

Put it this way. The family doctor cannot be expected to make long trips just to see that the patient is happy. If he is in the hospital, or near it, he should and will go up to the patient's room and look at his chart, and, which is quite allowable, make suggestions to the man who is handling the case. We do not think he should make suggestions to the patient that

such-and-such should be done which isn't being done. The more he hovers, the better for all concerned.

Now, should he charge for hovering? No, and we don't think he will, with an exception or two. If the family, for one reason or another, specifically requests him to go in, he should tell the specialist what he is doing and then everyone will know that he expects to be paid for that visit at least. Also, if there is a medical complication in a surgical case, then the family adviser is the one who should be consulted by

the specialist before a third physician is drawn in. If it is something for the family physician to handle, then he should be paid for handling it.

We feel that the doctor who refers a patient and then ignores him until everything is all over is too indifferent to be the family doctor any longer. We also feel that a patient who has more than a casual one-visit acquaintance with the physician who referred him will expect considerable attention from him. Occasionally he will expect to pay for it.

—Norfolk Medical News, Boston

### *Opinions From Here and There* (Continued)

**SPECIAL CITATIONS.** Two special citations were presented by the Association during the San Francisco meeting. During the presidential inauguration ceremony Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas P. Dallis, for his outstanding health educational service as the writing member of the team that produces the illustrated feature, "Rex Morgan, M.D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline & French Laboratories of Philadelphia for "pioneering use of television in bettering the health of the nation." The plaque was accepted for the company by Mr. Francis Boyer, president.

**ELECTION OF OFFICERS.** The election at the closing session brought the following results, in addition to the selection of Dr. Hess as president-elect:

Dr. Clark Bailey of Harlan, Ky., was named vice president.

Dr. David B. Allman of Atlantic City and Dr. F. J. L. Blasingame of Wharton, Texas, were reelected to their positions on the Board of Trustees.

Also reelected were Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. James R. Reuling of Bayside, N. Y., speaker of the House of Delegates, and Dr. Vincent Askey of Los Angeles, vice speaker.

Dr. J. Morrison Hutcheson of Richmond, Va., was named by Dr. Martin as a member of the Judicial Council to succeed Dr. Edward R. Cunniffe of New York, who served as Council chairman for many years. Dr. Homer Pearson of Miami, Fla., was elected new chairman.

Dr. W. Andrew Bunten of Cheyenne, Wyo., was elected a new member of the Council on Medical Education and Hospitals, succeeding Dr. W. L. Pressly of Due West, S. C. Dr. Charles T. Stone, Sr., of Galveston, Texas, was reelected to the same Council. Both terms run to 1959.

Dr. Floyd S. Winslow of Rochester, N. Y. was reelected to the Council on Constitution and By-Laws for a term ending in 1959.

Dr. Joseph D. McCarthy of Omaha, Nebraska, was reelected to the Council on Medical Service for another term running to 1959. To fill the vacancy created on the same Council by Dr. Hess' resignation following his election as president-elect, Dr. Robert L. Novy of Detroit, Mich., was selected.

The House of Delegates also chose New York City as the place for the 1957 annual meeting, San Francisco for 1958 and Atlantic City for 1959. Previously selected were Atlantic City for 1955 and Chicago for 1956. The dates of next year's meeting in Atlantic City are June 6-10.



# The President's Page

THE AMERICAN MEDICAL ASSOCIATION Meeting in San Francisco was very interesting. It was not as controversial as some in the past but was still a fine meeting. Our State Headquarters served baked ham to the visiting members and delegates. We think we made some friends. There was a large delegation from Indiana at the meeting and 68 of the physicians and their wives took the trip to Hawaii after the session. When we found out there were only 118 other physicians going to Hawaii we reasoned things must be pretty good in Indiana.

On Sunday before the A.M.A. opened, Dr. Stearns speaking at the Public Relations Conference, reminded us that not many years ago the organized medical profession was fighting Voluntary Group Health Insurance, which now represents the biggest bulwark against the advent of socialized medicine. He further said "I wonder if we may not cease looking for panaceas in the form of legislation, or lobbys, or commissions, and turn our attention back to ourselves. Admittedly, we have not made a howling success by one method; is it not time we try another and return to the basic virtues of the great profession?"

At the Civil Defense Conference, after getting us conditioned by showing the films of Hydrogen Bomb destruction, we were told that the government has stockpiled 85 million dollars of medical supplies throughout the country and has 21 million more on order. It is possible we should take Civil Defense more seriously.

At the House of Delegates they voted not to relax their opposition to non-service connected veterans' medical care.

The action on teaching in schools of osteopathy was deferred until the December meeting. It was felt the osteopaths will have to agree to have their schools inspected and graded by the A.M.A. Committee before anything further can be done along the line of recognizing them.

I think the highlight of the Convention was the article on the relation of cigarette smoking to lung cancer. As one of the men said "I haven't quit, but that article sure cut down my taste for cigarettes."

Just prior to the A.M.A. Meeting we learned that Dr. Lee Burney of the State Board of Health was to be recalled to Washington to serve in the position of Deputy Chief, Bureau of State Services. We contacted the Surgeon General and his assistant of the United States Public Health Service at San Francisco, as well as sent a wire to Mrs. Hobby requesting Dr. Burney be allowed to continue his work here. Evidently we didn't talk long enough as I just received a letter from Mrs. Hobby saying Dr. Burney would have to go to Washington unless he resigned from the service. They have extended his time until September 1 to allow the Governor to find his successor.

The Committee on Mal-Practice Insurance under Dr. James W. Leffel and through the help of the Department of Insurance of the State of Indiana has made recommendations that the cost of mal-practice insurance be reduced. These reductions are now in force with all companies who follow the Bureau's recommendations. They amount to roughly 10% to 35% reduction.

This is sure a hot summer to work, but my family likes to eat regularly.

*Wm Harry Howard M.D.*

# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

The National Convention is now history. Mrs. George Turner, El Paso, Texas, is now our national president, and Mrs. Mason G. Lawson, Little Rock, Arkansas, is our new president-elect.

Our own Mrs. Frank Gastineau again has been appointed National Chairman of the American Medical Education Foundation. I'm sure all our Indiana members will rejoice with me in the honor which has come to us, largely through her enthusiasm and devotion to this cause. Indiana received three awards for A.M.E.F. A "first" for the largest contribution per member at the State level. We averaged slightly above \$2.00 per member. Marion and Vanderburgh Counties also received awards for their large contributions.

It is the custom in Indiana for the immediate past president—Mrs. W. Burleigh Matthew in this case—to attend the National Convention, and give the president's report. Sue was also asked to appear on the Public Relations Panel, and give an account of the "Indianapolis Health Fair." She hunted up all the newspaper clippings, editorials, and other publicity she could find, and gave a splendid account of this affair. Another boost for Indiana!

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While you are all having wonderful vacations, or resting and relaxing during this summer period, auxiliary work is quietly going on behind the scenes. On June 10, 25 officers and committee chairmen from all over Indiana gathered at the Harvey Cottage on Winona Lake to get acquainted and make plans for the coming year. James Waggener, Executive Secretary of the Indiana State Medical Association, and Mr. Converse, of Blue Cross, were present and gave short talks.

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Mrs. Walter Portteus, program chairman, and her committee members, are relentlessly gathering material for the new program books. Officers and committee chairmen are working hard on their particular pages, making every effort to provide the county presidents and committee chairmen with clear, concise, workable material for their use during the coming year.

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Mrs. J. W. Mather, our president-elect, is working out plans, with her four vice-presidents and the district councilors, for meetings in each vice-presidential area to which all county presidents and presidents-elect will be invited. The purpose is to become better acquainted, exchange ideas, and to stimulate interest in auxiliary projects. It is hoped that the general discussion at these meetings will bring out many new ideas for auxiliary work.

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Our plans are maturing, and our goals are beginning to crystallize. You will learn more about these as the year advances.

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To all doctors who read this page, I would like to suggest that you secure a separate roster from *THE JOURNAL* for your wife. They are available at half-price—\$1 per copy—and she will have many uses for the roster of auxiliary members, by counties. The roster will be especially helpful to all state Auxiliary officers and committee chairmen. The roster, of course, includes all the ISMA members in the state, too.

Mrs. Harry C. Harvey, President.

## WITH YOUR APRON ON OR OFF\*

MRS. ROBERT SEIBEL

*Nashville*

I AM HAPPY to be here with you today to give you my viewpoint on a subject that you probably have been discussing and will have to make a decision about in the not too distant future.

There is a definite population trend in the United States from the urban to rural areas and, as always, wherever there are people there is need for good medical care.

I never intended to be a country doctor's wife because my husband and his partner never intended to be country doctors. They settled in the hills of Brown County as an expedient move until they could establish themselves and gain funds to set up practice elsewhere. However, after six years we are so engrossed in community work that we all feel we have found our home.

I am not here today to sell you a bill of goods on being a country doctor's wife or anything like that. My only purpose is to acquaint you with some of the life and experiences that come to one—or at least have been mine while my husband has had a practice in a rural area.

Service—a doctor's life is primarily one of service. In a small community the opportunities for service are unlimited. He serves not only medically but as family advisor and in various church and civic groups. Due to the close association of the doctor and his wife in the eyes of the people, the wife also has a job to do. That can either be a chore or an enjoyable experience.

In return for his services, the doctor and his wife are given a position of respect in the community, and the people will do their "darndest" to do a good job for the entire family. I find that I get just a little better service on my

household appliances, and our experiences recently when we built our new home were that everyone was on the job to do their best.

We have the feeling of belonging.

We feel that we are needed.

I'll admit that my life is a little hectic. I have no daily routine so I couldn't possibly outline a typical day for you. The phone rings constantly. Even though we have office help they, too, sometimes call for advice. Sometimes I can be of assistance; sometimes I feel very inadequate.

It is sometimes necessary to track down my husband when he is 20 miles out in the hills on a call, and I have another call for him in that same area. In these cases the telephone operator is one of my best friends. We are usually able to locate him just in the nick of time.

It took a little while to become accustomed to the natives' way of giving directions. They would frequently call and say, "Oh, just tell the Doc to come out Greasy Creek and turn at the fork in the road. The house is just over the hill. Now you may have to walk in just a piece from the road." Very often that little "piece from the road" would be half a mile and then my husband would find an isolated shack. We have very few difficulties along that line now as we know the forks in the roads and where most of those little shacks are.

As I said before, these things add to the confusion of my day. My husband is in and out of the house at odd hours for meals but I don't say that is particularly typical of rural practice. Doctors' wives all become accustomed to that. I am thankful, though, that we live in a small place and that he can get home from the office in a minute or so for those meals. I see a lot more of him this way and so do the children. Those hours he would spend driving through traffic if we lived in a city, he can spend at home with the children. My daughter,

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\* Presented to the Senior Class Day audience, composed of I. U. senior medical students and their wives, May 1, 1954 in Indianapolis. The program was sponsored by the Rural Health Committee of Indiana State Medical Association.



who will soon be four, has been going out on country calls with her daddy since she was two. She is much closer to him because of this and enjoys the rides in the country. Sometimes an elderly patient can be cheered by a small child, too.

One thing that appeals to us is the informality of living in our small town. We enjoy the lack of class consciousness, people accept us for what we are, not for what we wear or our material possessions. We dress casually when we please. Entertaining is informal and, as you all know, a little less expensive when done that way.

There is a great deal of social activity. In fact I have been surprised at how busy a little place it really is. Church groups are very active. As is true in most small towns the church has little income and that makes for an active church. It is a challenge to most of us to get out and work for the improvements that we need. There is an active Lions Club, Masonic order, TB association, even a garden club for those who are interested. We, of course, are fortunate in having the artists' group with us. They add color to the community.

The community spirit is very high. When someone needs help it is there.

Nashville has always been a poor town because much of Brown county land lies in the state park and is therefore not taxable. We really have to work to get things like a fire truck, water and sewage systems. But the will is there. We have the water system and the fire truck and soon hope to have a sewage system.

I told you at the very beginning that I had never intended to be a country doctor's wife, but I had always secretly hoped that he would settle in a small place. I like the idea of having room to spread out, a large garden, a safe place for my children to play minus city traffic. I like the relationship I have with the patients who feel free to drop in for a chat now and then. Those who farm bring us chickens and fresh vegetables—not in payment of bills but just because they feel like giving them to us.

From what I've said it may seem that I am quite biased in feeling that a country doctor's life is the best. Actually, the location doesn't make too much difference. It is my husband's job wherever he may be to practice the best kind of medicine he knows and it is my job to make a happy and comfortable home.

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## STUDIES HOUSEHOLD POISONING PROBLEM

Believing that "a stitch in time" saves lives, the AMA Committee on Pesticides currently is undertaking a program designed to inform both physicians and the public on the uses and dangers of various drugs, chemical products and pesticides used around the home. The program was spearheaded by a recent Committee proposal to organize a companion group under the Council on Pharmacy and Chemistry to delve more fully into the toxicologic effects of these products.

So far the Committee has laid extensive groundwork by: (1) Compiling lists of trade names and case histories of poisonings from these household chemicals; (2) Developing criteria for evaluating the safety of toxic materials, and (3) Preparing an exhibit, a radio transcription series and a pamphlet urging the public to guard against poisonings resulting from the use of various household chemicals.

## THE PLACE OF THE GENERAL PRACTITIONER IN MEDICAL EDUCATION OF TODAY\*

DR. J. R. BENDER†

*Winston-Salem, N. C.*

THE Collections of Hippocrates is a series of brief generalizations suggesting an aged physician's reflections on the experiences of his lifetime, and many of these experiences have been confirmed over and over again by physicians and scientists of the present age, and these reflections are still held in high esteem and quoted as medical proverbs today. Hippocrates, the physician, was no specialist, but a general practitioner who adopted an expectant kind of treatment, realizing that the tendency of the body is to heal itself if the physician will only content himself to wait upon nature. The philosophy and teachings of this physician of the fifth century before Christ are still the creed of medicine today. We, in the medical profession, should not only reread (or commit to memory) the Oath of Hippocrates, but we should reinstate it in our medical curricula; and reflect deeply upon the spirit of the Hippocratic passage: "I will teach this art to them who would learn it and I will impart this art by precept, by lecture, and by every mode of teaching according to the law of medicine. The regimen I adopt shall be for the benefit of my patients, according to my ability and judgment, and not for their hurt or for any wrong."

Any discussion of postgraduate education necessarily means planned education subsequent to graduation, and connotes special or advanced training in a particular art or science. This hypothesis leaves much to be desired in the sense of my discussion this morning. It becomes necessary in my outline, "The Place of the General Practitioner in Medical Education," to admit that

medical education is postgraduate training and advanced training in medical science; but, the big question: "From where do we begin and where shall we end in the program of postgraduate education in medicine?" poses a problem which seems to have no definitive answer. This is true of the specialist, as well as the general practitioner. The specialist, as defined: "The man who continues to learn more and more about less and less until he comes to know everything about nothing," is still an uneducated individual, without a fully developed answer.

It is axiomatic that a success in the practice of medicine depends in no small degree upon keeping informed about current advances in the field of medicine; and, the most important means of accomplishing this is to keep abreast of contemporary medical literature. Today this is entirely impossible, even for the most astute and enthusiastic physician scholar, due to the multiplicity of journals devoted to various aspects of clinical medicine and medical advances which have taken place within the past few years. In a recent survey it was found that there are approximately five hundred medical journals published in the English language alone, and two-thirds or more of this number are published in the United States. As medical research continues, medical specialization increases and the problem of medical education becomes more sagacious and complex.

A recent editorial of an outstanding medical journal made this comment: "If you read three hours each night, attend local society meetings regularly, and go to postgraduate courses at least twice a year, keeping up with medicine is still difficult." This emphasizes the impossibility of anyone "keeping up with medicine." However, it does not give reason for the defeatist attitude

\* Read before the Tri-State Medical Association, Charleston, S. C., February 23, 1954.

† Dr. Bender is vice-president of the American Academy of General Practice.

of "what's the use?" which has developed among many physicians. Instead, it emphasizes the necessity of unified courses of instruction in the medical schools with the practicing physicians.

The American Academy of General Practice has as one of its primary objectives "to promote and maintain high standards of general practice of medicine and surgery . . . through providing post graduate study courses for general practitioners." The basic philosophy of the Academy is to improve standards and quality in medical practice among the general practitioners who, themselves, render four-fifths of the medical care in this country. President Robins, speaking before the Congress of Delegates of the Fifth Scientific Assembly of the American Academy of General Practice in 1953, said: "If I could resolve the essential purpose of the AAGP into one sentence, I should say that its real purpose is to render a better quality of medical care to the American public. We all know," he continued, "it is more difficult to be an excellent general practitioner than it is to be an excellent specialist, because the general physician must cover the broader field of knowledge . . ."

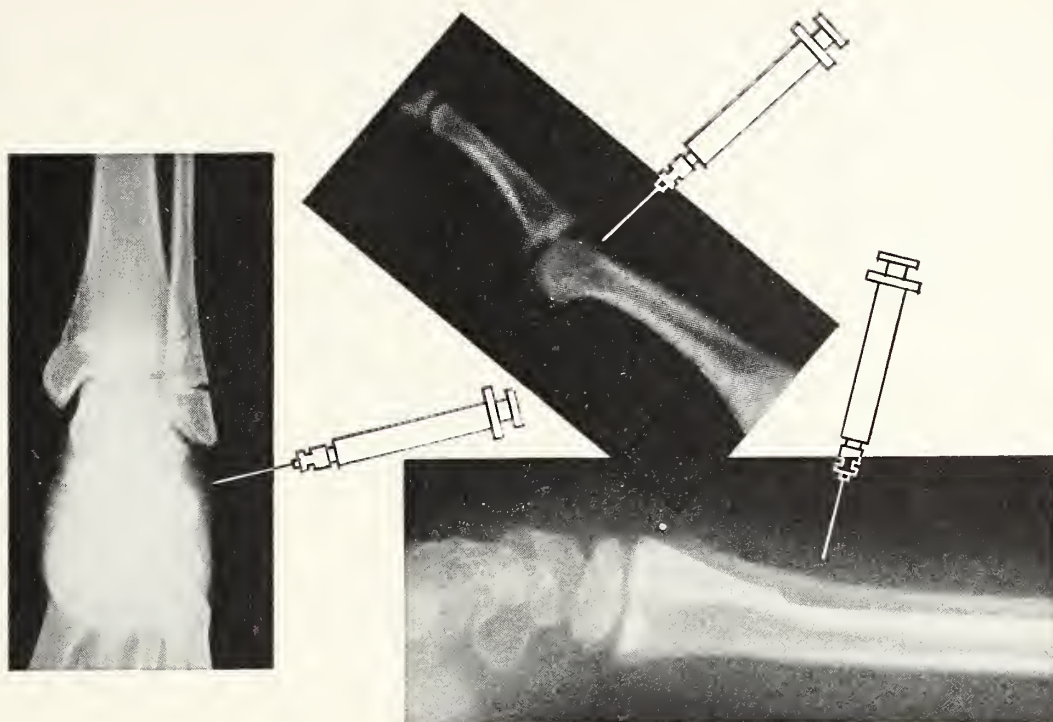
Membership in the Academy of General Practice is, and will increasingly be, a badge of distinction, indicating significantly to the American people and to the medical profession of America that the member of AAGP stands out as one who is doing his best to be an up-to-date, well-qualified medical practitioner. Despite these aims and high objectives, there are many physicians who lose membership in the Academy each year due to insufficient postgraduate educational credits. It is paradoxical, however, that of those twelve hundred to fifteen hundred members dropped from the membership each year due to insufficient postgraduate credits, a majority were graduated within the past ten years. Medicine is progressing so rapidly that eighty per cent or more of the routine prescriptions today could not have been filled by the pharmacist ten years ago; and, less than twenty per cent of the commonly used prescriptions of a decade ago are familiar to the medical graduate of today. Dr. Donald Anderson, Dean of the Rochester University School of Medicine, the former Secretary to the Council of Medical Education and Hospitals of the American Medical Association, recently said: "Much that the physician needs to know five years or less after graduation was not taught him in medical school be-

cause it was not known to anyone at that time." This statement re-emphasizes the need of continuous postgraduate training for the physician in medical practice.

Those physicians who do not attend postgraduate courses, medical assemblies, seminars, or take part in clinical lectures voluntarily each year, should be required to take a course of postgraduate work in order to retain their license to practice. To some, this may seem a vindictive statement, without regard for the integrity of the professional colleague, those busy physicians who cannot leave their practice, or those who limit their practice and become pseudo-specialists. My reply to this can be exemplified by a few cases in North Carolina: (1) A young medical graduate, practicing in a town with fifteen other physicians, was licensed to practice in North Carolina in 1946. After two years of membership in the Academy he resigned because: "cannot get the required credits for continuous membership—unable to leave practice." A colleague in the same town who had been in practice for a shorter period of time reported more than twice the number of required hours that same year. This so-called isolated physician lives less than thirty-five minutes drive from a teaching hospital, accredited for intern and residency training, which conducts clinico-pathological conferences, ward rounds, medical lecture series, etc., each week, which would have more than supplied him with enough hours credit each year, without his having to leave his home. (2) Another physician resigned for the reason: "cannot afford to leave practice—am in an isolated community with only three other physicians." Leaving his practice, however, was no problem New Year's Day to go to the Sugar Bowl Game in New Orleans, or no problem in October at the time of the World Series Baseball Games in New York City. Physician number three, the most naïve of all, does not need to continue his medical education. He resigned from the Academy after two years membership with the notation: "I have not taken any postgraduate courses since I went into specialization last year; therefore, I do not have any hours to report." He was asked the question: "Why not report the specialty courses which you have taken for postgraduate credit?" Answer: "I have not taken any specialty courses; I have just

(Continued on page 888)





## Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery<sup>1</sup> where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means<sup>1, 2</sup> of accelerating dispersion of accumulated fluids.*

Swenson<sup>2</sup> has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anes-

thesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.

limited my work to a specialty." Question: "How, and to what specialty?" Reply: "Well, uh, no specialty in particular, I'm just not a general practitioner any more, as I do not make any home calls or practice outside of my office or the hospital." Three actual cases; three practicing physicians who have failed to "keep up," not for a reason, but as an excuse. They are now specialists, by their own definition—a definition which works in reverse. It's not special training in a limited field, but limited training in every field.

Medical education poses a problem, both for the medical faculty and the practicing physicians. The American Academy of General Practice shall continue to hold yearly postgraduate education as essential for continuous membership; and, the Academy will continue to work with medical educators and clinicians to bring the latest medical knowledge to the communities of the physicians in practice. Every medical faculty has co-operated with the Academy to the fullest in this undertaking. But, neither the medical schools nor the AAGP can render to the American people a better quality of medicine and better medical care when those physicians who are in practice fail to keep up, and compensate for their lack of knowledge by limiting themselves to hospital and office practice. This type of pseudo-specialization has produced a type of professional bureaucracy which plays one medical specialty against another and one individual physician against another for a place of priority on hospital staffs and in medical clinics. It has caused the medical profession to be called a "medical trust," spoken of in such bellicose terms as are usually reserved for big business, with little regard for the individual doctor or the integrity of the profession. This malignant condition has recently been brought to the attention of the public by such eye-catching headlines as "Patients For Sale"—"Too Many Unnecessary Operations"—"Ghost Surgery"—"The Evils of Fee-Splitting"—"Some Doctors Should Be in Jail"—etc. None of these articles have served to improve the professional and public relations of the medical doctor. Instead, they have brought to the attention of the American public the evils in our honored profession.

Perhaps these articles were written mainly for the sensation of the press and magnify the

actual evils which exist, but the infectious organism of poor public relations does exist in the medical profession and it behooves us individually and collectively, general practitioners and specialists alike, to unify ourselves in an effort to cure the evils which exist and to eradicate and help prevent this devastating illness in the future. It is hard to explain why we teach the medical student so much about the science of medicine and so little about the art of medicine. We teach him to be *a* doctor, instead of *the* doctor; the difference here is undeniably great. The industrialist, the financier, the average American citizen respects and admires his family doctor as a counselor, a friend, and a servant when illness strikes. But the average citizen has little respect for the American doctor as a counterpart of the learned and scientific medical profession; and, he often holds resentment and contempt for the physician as a citizen and community leader.

A few days ago a business friend of mine asked: "Is the reason doctors hold themselves aloof to the public because of timidity, or a superiority complex?" Those of us who are especially interested in the educational program of medicine would do well to ponder this question, for here is the facet of the medical student's education into which the general practitioner fits and for which he is better fitted than any other person in medicine. Dr. Paul R. Hawley said: "I can observe deficiencies in the medical graduate today which offer a great opportunity to the medical (fraternity) profession. These are not deficiencies in the professional education and training, which are definitely better than in my student days, and which never before in the history of medicine have been so good . . . nevertheless, the medical graduate has never been so poorly prepared as he is today, actually so completely unprepared, to face the complex problems by which he will be confronted the moment he enters private practice. It is a tragic paradox that with a professional armamentarium never before equalled, today's medical graduate is handicapped in applying it to the general good of humanity by his ignorance of the social and economic structure within which he must serve." It is in the facet of the social and economic structure of medicine that the general practitioner best fits and in which lies his great-

(Continued on page 890)



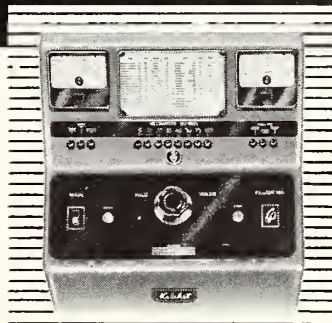
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est opportunity, an opportunity to train the medical student as well as improve public and professional relations for the medical fraternity which is so necessary if we are to stay the tide of socialism in medicine.

The medical student of today is being taught the science of medicine, but is he being taught the art of medicine? My formal training was as good as this country had to offer at the time of my student career; and my hospital training was likewise basic and well-rounded in technique and decorum. But, the laboratory in which I learned the art of medicine was not to be found in the halls of the medical college or on the wards of the three hospitals in which I trained; instead, it was the office of an old practitioner, a medical graduate of the turn of the century. Perhaps I should have more loyalty to my alma mater than to admit that it failed to teach me the art of the practice of medicine; but I ask this question: "Are the five thousand or more medical students who are to be graduated from the accredited medical schools and colleges this year getting any instruction in the art of medical practice?" Did their curricula in the pre-clinical and clinical years include a course in the art of medicine? Do our hospitals offer instruction in the humanitarian side of medical practice? Are clinical conferences held in the art of practice for the internes and house officers as they are in surgery, medicine, cardiology, etc.? There is a need for such instruction in the medical schools. Every medical faculty should include two or more general practitioners who have served in the field of practice for a period of at least ten years and who are still in active practice. These general practitioners should meet with the students regularly in the same status as the radiologist, the pathologist, or the dermatologist, and talk with them about the art of medicine. In this field of teaching, the general practitioner should tell the student who is approaching the threshold of medical practice what he should expect of the community in which he locates and just what the community will expect of him.

In the profession of medicine, as in the field of business, we should first study the demands and the needs of the consumer public, and then try to create a product which will be useful.

This product should be properly distributed to best meet the needs of the consumer. In other words, the people need adequate medical personnel, easily accessible, and readily available and only through careful planning and with a change in the approach to our medical education and training can this be done. When people in the small towns and rural communities become acutely ill, they need medical care; and combined with the scientific professional and surgical care of the emergency curative type, they need the therapeutic type of care which will require of them the least time away from their homes and their work, the least expense in money, and the least amount of inconvenience to the patient and family. For this type of medical care, they need a physician who is properly trained and who has a broad basic understanding of the human needs and necessities of life, along with the best scientific medical training that the medical colleges can afford. This physician should be taught and taught well, on a parity with specialists, how to care for the acute infectious diseases, the accidents, the acute surgical conditions, and the acute medical emergencies. He should also be taught how to recognize the persistently difficult problems which require the care and/or consultative assistance of the physician in specialty practice. This co-operation with his specialty friends would eradicate the general practitioner's feeling of being inferior or persecuted and develop a feeling of professional and social equality.

The young graduate who is entering the profession of medicine could then expect remunerations to justify the additional effort, work and responsibility that he has assumed and could create a professional friendship with the best possible medical clientele. Thus, he could feel justly proud of his proficiency in the ranks of organized medicine, restore prestige to the physician who has felt he has lost it, restore the community's pride, and put the large medical centers in their proper place by maintaining the lesser procedures on a lower level where they would be less expensive to handle.

This general physician could fit just as easily in the suburbs of our large cities or the professional buildings of our medical centers as in the

rural communities and become the family counselor in the whole scheme of medical practice. Thus, the general practitioner would give that intangible something to the profession which does not come from the textbooks, nor is it discovered in the laboratories, but comes only from a close personal contact and mutual understanding between a physician and his patient. We medical doctors have our assets and our liabilities in our public and professional relations. We are walking in our own light if we do not pass to the young medical graduates of today the dignity and glory of the heritage which has been ours to enjoy in the art of medicine, as well as the science of medicine.

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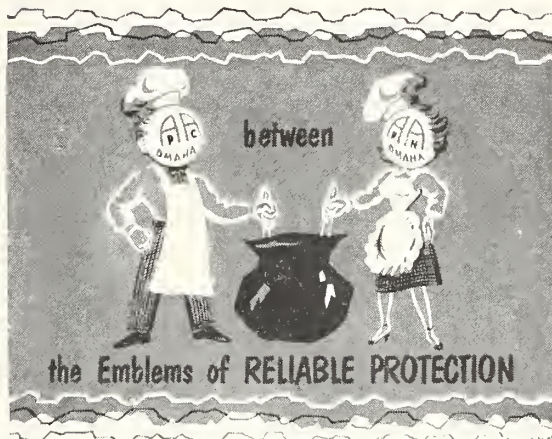
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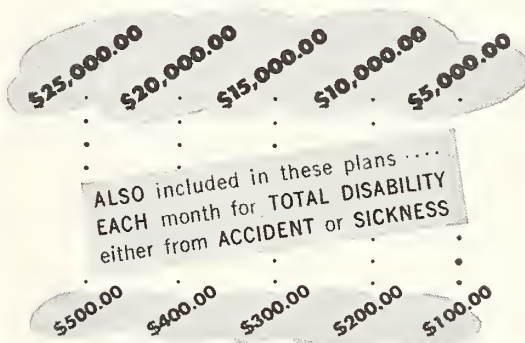
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## PLEA FOR HOSPITAL PRIVILEGES

FOUNT RICHARDSON, M.D.\*

*Fayetteville, Arkansas*

**T**ODAY we of American Medicine are standing at the crossroads. In the face of some of the glowing achievements of the sciences, we may be seeing the last days of the practice of medicine as we have known it. No Moses has yet appeared to lead us out of the wilderness. While some of us have slept, the ranks of the family doctor have been thinned, have in some areas been decimated. In some hospitals one is not allowed to have his family physician. This is true of Cleveland. A few private practitioners of medicine still exist, but in the hospitals in some of our cities, a general practitioner cannot take a patient to a hospital, study his condition, and diagnose and treat his case. Incredible? Go out and ask the general practitioner in this city. Is that to happen to all of us? In your town?

What has been the result of these changes? The only thing that can happen—the patient falls into the hands of the specialist, he becomes a case. He is shunted about from specialist to specialist, and his medical expenses increase. No wonder he begins to complain. The American public is long-suffering but something has to break. The price of having so many specialists has driven many people into demanding that the Government do something about it. From that, we members of the grand old profession have had to fight for our freedom to practice ethical medicine. We general practitioners in American medicine have stood as a protection against the gougers and the fee-splitters for five generations. We have directed the medical care of the whole being of our patient and have called

in the highly trained technicians, surgeons, radiologists, cardiologists—only when we needed them. That is the way it should be.

The truth is that every patient needs a doctor who can watch the whole course of his medical care. With what ability could a specialist skilled in orthopedics, treat a broken bone, and at the same time, watch and care for that patient—if he had at the same time a diabetes, hypertension, and a failing heart?

Who will be the patient's friend? That's part of the treatment and if you don't believe me, you have a lot to learn. Are we to have six technicians treat a patient when one man, broadly educated in the total science of medicine, can do this effectively? Why should the patient be subjected to six specialists, when his family doctor could do most or all of these things? No wonder medicine is expensive. No wonder a howl of derisive laughter goes up when a radio punster describes a consultation as a case where a wealthy man is ill and a doctor walks in and says, "Well, well—here's a sick man with lots of dough—let's call in all our friends."

The family doctor has for years protected the patient from such greed, from the ghost surgeon, from the empirical formula that a well-qualified specialist in pediatrics can't treat you if you're over 12 years old.

The truth is that these artificial barriers are all bunk. The truth is that they have pushed the original physician into the background. We, who have cared for the public in a manner which has constantly improved, are told that we may no longer treat our patient, if he is in a hospital.

The truth is that a resentment against these barriers is increasing among the thinking public

\* Presented to Congress of Delegates, American Academy of General Practice, Cleveland, March 1954.



to the extent that they are eyeing government medicine as the answer. I feel as Mark Anthony, that "Judgment has fled to brutish beasts and men have lost their reason."

Why stand we here idle? The American Academy can and will point out the way whether in resolution or in staff meeting—whether in secret caucus or in the headlines—we will demand that every patient in every hospital in America be given the protection of having a qualified general practitioner as a safeguard in his case.

We will demand this care to be provided in every hospital. This, only, can protect that patient from the neglect of some other condition not in the field of the average specialist.

He can protect his patient against the "surgery-for-money" specialist. He can save the patient from gougers. He can keep the cost of medical care within reason. He can warn his patient against the fee-splitting surgeon.

The time is already late for us to act. But it's not too late.

Our accrediting agencies must institute a rule that in every hospital in America a patient be given the right to the protection of a general practitioner. In this contention, we are right. Right is a good thing to have on our side.

The regulation of hospitals must go to where it belongs—to all the doctors who are on its staff. These rules could be put into practice within a few weeks.

Instead of "referring" our patient to a specialist, we will call the specialist and have him come to the patient, under our protection and under our guidance. We will call for assistance whenever we feel that it is to the best interest of the patient, and we will retain complete direction of that patient's care, being advised by other helpers. We will continue to be our patient's best friend.

To repeat, our demands are simple:

1. Open every hospital to the family doctor.
2. Return every patient to the immediate care of his personal physician and whatever technical assistance his physician might feel is required.
3. Require immediate revision of the rules of the various regulating agencies (the Joint Commission) to effect the rules above.

This leadership rests in our Academy. Our cry must echo from every state and every country. No, it must be heard from every city, village, hamlet. It must be heard from every sick-bed. We general practitioners hold the key to a happier day for the American public and the qualified doctor of every kind. We are standing at that door.

Thrice bold is he whose cause is just—what have we to fear?

May we, today, turn the key, and unlock the door to a happier tomorrow.

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# RESOLUTION SUBMITTED TO A.M.A. HOUSE OF DELEGATES, SAN FRANCISCO June 1954

## RESOLUTION

(To seek endorsement of a program for "A Family Doctor for Every Doctor's Family," sponsored by the American Academy of General Practice)

WHEREAS, The health needs of the American people can adequately be met only if there is an ample number of able and efficient practitioners of medicine, and

WHEREAS, The health of America's doctors is thus a matter of grave concern not only to the individual doctors, their families, and the entire medical profession, but to the public as well, and

WHEREAS, It is a well recognized and deplorable fact that the physician is often the last one to heed advice he urges upon his patients and thus often goes without periodic examinations or without the advantage of a personal physician who maintains an accurate health record of the individual physician and the members of his family, and

WHEREAS, Failure to heed his own advice, and failure to employ the services of a family physician for himself and his family may be directly related to the fact that the average expectancy of physicians in America is appreciably lower than the average expectancy of males generally, and

WHEREAS, The members of a physician's family are deprived of adequate and proper medical care if they resort to first one and then another of the physician's medical colleagues with no single individual filling the role of a personal physician for the family and maintaining a continuing health record for each member of the family, and

WHEREAS, The American Academy of General Practice, at the instigation of its late vice-president, Dr. Merrill Shaw of Seattle, has launched a program to persuade every physician in America to select a regular family physician for himself and his family, and

WHEREAS, This program, which has attracted wide-spread attention in newspapers and popular magazines, is setting an important precedent for the lay public, which, if followed, will improve the nation's health and simultaneously the good will enjoyed by the medical profession, now, therefore, be it

RESOLVED, That the American Medical Association commends the American Academy of General Practice for its meritorious efforts in the furthering of this worthy project, and be it further

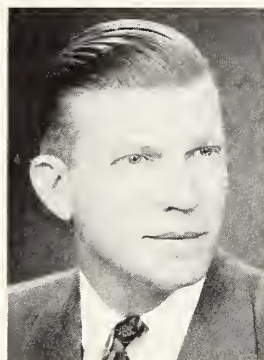
RESOLVED, That the American Medical Association hereby endorses the Academy's project and urges every member of the Association to support the program and cooperate in it by taking upon himself the responsibility of designating a physician to serve as family physician for his family, thus setting a prime example of good health practice for his patients and the people in his community.

## Activities of the INDIANA ACADEMY OF GENERAL PRACTICE

CHARLES G. DOSCH  
*Executive Secretary, IAGP*

### *District Chapters:*

At the Sixth Annual Scientific Session of the Indiana Academy of General Practice, April 14 and 15, 1954, it was agreed by vote of the membership to organize component chapters of the State organization. The growth, and the consequent expanding needs of I.A.G.P. made this decision mandatory. These component chapters conform with the 13 Districts of the



Charles G. Dosch, recently appointed part-time executive secretary for I.A.G.P., tells of Academy plans which will keep officers busy during the coming months.

Mr. Dosch is well-known in Indianapolis amateur theatrical ranks. He has played leading parts in Civile Theatre and Starlight Musical productions for several years.

Indiana State Medical Association. It was further agreed that I.A.G.P. would set up a House of Delegates as soon as seven districts had organized and adopted the State Constitution and By-Laws, each of the District Chapters to elect three delegates to serve in the House of

Delegates of I.A.G.P.'s Annual Scientific Session.

The burden of organization has almost automatically fallen on the I.A.G.P. Board Member of each district and, due to their strenuous efforts, it appears most likely that the Academy will have a functioning House of Delegates at the next Annual Meeting, to be held at the Antlers Hotel on April 13 and 14, 1955. To date, charters have been issued to eight District Chapters and five Chapters have completed organization.

### *Mead Johnson Award:*



At the Indiana University School of Medicine's Annual Alumni Day program, May 12, a certificate of the 1955 Mead Johnson General Practice Scholarship Award was formally presented to John Harmon Phillips of Princeton. Dr. O. T. Seamahorn, President of the Indiana Academy of General Practice, made the presentation speech at the meeting, before nearly 500 Indiana University School of Medicine graduates. Mr. Phillips is a senior student at the Indiana University School of Medicine and will start his general practice residency in July, 1955. Mr. Phillips received his A.M. degree at Indiana University. He is a member of Phi Gamma Delta, Phi Eta Sigma, Phi Beta Kappa and Blue Key. He received three varsity letters in baseball and was the recipient of the Big Ten medal for athletic and scholastic achievement. Heretofore, Mr. Phillips' entire medical education has been financed from money he received from insurance left by his father, and his work during the summer months.



*Exhibit at State Medical  
Association Convention:*

Don't fail to visit the I.A.G.P. booth at the Indiana State Medical Association Convention at Murat Temple. We are very fortunate to have this space allotted to us. Some member of I.A.G.P.'s staff will be at the booth at all times to greet our friends in the Medical Association. Information on the Academy's activities will be obtainable from the I.A.G.P. representative, and all questions pertaining to membership will be answered.

*Road Shows:*

Dr. Lester Bibler, Indianapolis, and Dr. Francis Land, Fort Wayne, Co-chairmen of the I.A.G.P. Road Show Committee, are now in

process of lining up locations and speakers for the 1954-55 program. This is one of the Academy's ways of helping the General Practitioner to keep up his Postgraduate studies. Thus far, Dr. Bibler and Dr. Land have arranged the following meetings:

October 13, 1954: Gary, in conjunction with the Indiana Medical Association's 10th District Meeting and the Lake County Medical Society

November 17, 1954: Vincennes, jointly with the Knox County Medical Society

December 7, 1954: Fort Wayne, with the Allen County Medical Society

February 10, 1955: Evansville, with the Vanderburgh County Medical Society.

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## HIGHLIGHTS OF SPECIAL INTEREST TO THE G.P. ON I.S.M.A. CONVENTION PROGRAM

INDIANA general practitioners will find several programs of particular interest to them during the 105th Annual Convention of Indiana State Medical Association in Indianapolis on October 24, 25, 26 and 27.

Highlights of special interest include:

1. General meeting, Murat Theatre, 9:30 a.m., Tuesday, October 26.

### *"Medical and Surgical Emergencies"*

General Practice participant: George L. Thorpe, M.D., Wichita, Kansas. His topic: *"General Practice Emergencies."* Dr. Thorpe, a founding member of the American Academy of General Practice, has a busy general practice in Wichita and has been a member of the House of Delegates of AAGP since its beginning. He helped organize the Kansas chapter and has been one of the leaders in general practice organization. He had a long tour of duty with the Air Force in World War II. He will fly his own plane from Wichita, with his nurse-wife, to appear on this program.

2. General Practice Section meeting, Wednes-

day, October 27, Egyptian Room, 2:00 p.m.

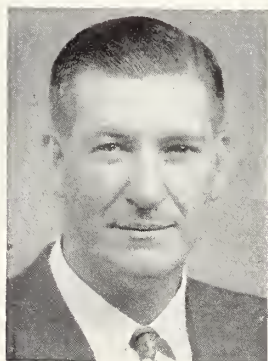
*"Modern Office Therapeutics"*—George L. Thorpe, M.D., Wichita, Kansas.

3:00 p.m.: *"The Problems Facing Family Physicians Today"*—John "Jack" S. DeTar, M.D., Milan, Michigan.

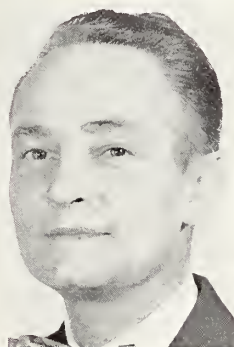
Dr. DeTar is now serving his third term as Speaker of the House of Delegates of the American Academy of General Practice and has served as Speaker of the House of Delegates of the Michigan State Medical Association. Dr. DeTar has a large general practice in Milan. He has been active in Blue Cross-Blue Shield on a national level. He is a member of the House of Delegates of the American Medical Association and is now serving as a member of the special 5-man committee of AMA to deal with improper releases of medical information to the public. He has made appearances before medical audiences in many states.

4:00 p.m.: Business meeting and election of officers for 1955.

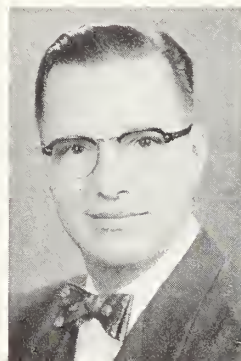
Officers of the Section on General Practice of the Indiana State Medical Association selected much of the material for this issue of THE JOURNAL. Pictured below they are: Norman R. Booher, M.D., Indianapolis, chairman; Frank H. Green, Jr., M.D., Rushville, vice-chairman; and Russell J. Spivey, M.D., secretary. Dr. Spivey is president of Indianapolis Medical Society and all three officers are also active in I.A.G.P.



Dr. Booher



Dr. Green



Dr. Spivey

## NOTED CANCER SCIENTIST TO HEAD TOBACCO INDUSTRY RESEARCH COMMITTEE

**T**HE Tobacco Industry Research Committee has announced the appointment of Dr. Clarence Cook Little, internationally-noted cancer scientist and former university president, as director of its newly organized scientific research program.


Dr. Little is a former president of the American Association for Cancer Research and served as a member of the National Advisory Cancer Council. He was president of the University of Maine (1922-25), and the University of Michigan (1925-29).

Announcement of the appointment was made by O. Parker McComas, chairman of the industry committee, who revealed that Dr. Little's duties would include chairmanship of the committee's seven-man Scientific Advisory Board.

The industry committee was formed early this year to sponsor research into all aspects of tobacco use and health.

Dr. Little is now director of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, one of the world's greatest research centers specializing in genetics. He will continue in that position, dividing his time between the Bar Harbor laboratory and the work of the tobacco industry research program. The Jackson Laboratory breeds one million mice a year for various experimental studies at Bar Harbor and in some 400 other laboratories.

The new director will be responsible for guiding the administration of the entire research program. The Tobacco Industry Research Committee has undertaken a long-term commitment

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<p>Write for descriptive booklet</p> <p><b>THE CINCINNATI SANITARIUM</b></p> <p>5642 Hamilton Avenue Cincinnati 24, Ohio</p> <p>Telephones: Klrby 0135, Klrby 0136</p>	



to provide funds for the program and has made available an initial fund of \$500,000 for the remainder of this year.

Members of the Scientific Advisory Board, in addition to Dr. Little, are Dr. McKen Cattell, Professor and Head of the Department of Pharmacology, Cornell University Medical College, New York City; Dr. Leon Jacobson, Professor of Medicine, University of Chicago, and Director of the Argonne Cancer Research Hospital, Chicago; Dr. Paul Kotin, Assistant Professor of Pathology, University of Southern California Medical School, Los Angeles.

Also, Dr. Kenneth Merrill Lynch, President, Dean of Faculty and Professor of Pathology, Medical College of South Carolina, Charleston; Dr. Stanley P. Reimann, Scientific Director of The Institute for Cancer Research and Director of The Lankenau Hospital Research Institute, Philadelphia; and Dr. William F. Rienhoff, Jr., pioneer lung surgeon and Associate Professor of Surgery, Johns-Hopkins School of Medicine, Baltimore.

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Indianapolis—October 25, 1954

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2 to 3	Course 13 Treatment of Congestive Heart Failure	Course 14 Proper Use of Fluids and Elec- trolytes in the Surgical Patient	Course 15 What Can Be Done for the Arthritic?	Course 16 Cancer of the Lung	Course 17 Treatment of Thyroid Disease	Course 18 Diagnosis and Treatment of Common Skin Disorders
3 to 4	Course 19 Office Manage- ment of Minor Psychiatric Disorders	Course 20 Indications for Surgery in Car- diac Conditions in Adult	Course 21 Practical Appli- cations of Rou- tine Laboratory Procedures	Course 22 When Is Hysterectomy Justified?	Course 23 Obstructive Disorders of the Urinary Tract	Course 24 Diagnosis and Treatment of Common Skin Disorders
4 to 5	Course 25 Treatment of Infectious Disease in Children	Course 26 Office Gynecology	Course 27 Management of Hypertension	Course 28 Present Concepts of Management of Peptic Ulcer	Course 29 Management of Diabetes Mellitus	Course 30 Differential Diagnosis of Jaundice

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## INDIANA SENDS LARGE DELEGATION TO A.M.A. MEETING: SEVERAL HOOSIERS HONORED

**I**NDIANA STATE Medical Association was officially represented at the 103rd Annual Meeting of the American Medical Association in San Francisco, June 21-25, by the four members of the House of Delegates, Cleon A. Nafe, M.D., Indianapolis; Eli S. Jones, M.D., Hammond; Alfred H. Ellison, M.D., South Bend; and Wendell C. Stover, M.D., Boonville.

One hundred and seventy-five members of the Association were registered by A.M.A.

### ON THE PROGRAM

Appearing on the programs of the Scientific Assembly were Hugh A. Kuhn, M.D., Hammond, who was secretary and a member of the executive committee on the Section on Laryngology, Otology and Rhinology; Carl H. McCaskey, M.D., Indianapolis, also a member of that executive committee; and Kenneth L. Craft, M.D., Indianapolis, who opened a panel discussion on "Allergy in Otolaryngology."

In the combined meeting of the Section of Ophthalmology with the Association for Research in Ophthalmology, Corley B. McFarland, M.D., South Bend, presented a paper on "Heredomacular Degeneration" and Theodore F. Schlaegel, Jr., M.D., Indianapolis, spoke on "The Liebmman Effect in Binocular Perception."

### WIN HONORS

Two Indiana exhibits entered in the Scientific Exhibits were awarded A.M.A. Certificates of Merit by the Committee on Awards. In the Section on Experimental Medicine and Therapeutics, W. R. Kirtley, S. O. Waife, A. Staub, M. Root, and O. M. Helmer, of the Lilly Research Laboratories and Indianapolis General Hospital, won a citation for the exhibit on "Glucagon, the Hyperglycemic-Glycogenolytic



Indiana's delegates to the American Medical Association's House of Delegates are pictured above in a pre-convention conference in the Palace Hotel, San Francisco.

Discussing matters scheduled to come before the House were, reading from left to right, James A. Waggener, executive secretary of I.S.M.A.; Cleon A. Nafe, M.D., Indianapolis, delegate; Eli S. Jones, M.D., Hammond, delegate; Alfred H. Ellison, M.D., South Bend, delegate, (back to camera); Walter L. Porteus, M.D., Franklin, president-elect of I.S.M.A.; and Wendell C. Stover, M.D., Boonville, delegate.

Factor of the Pancreas." In the Section on Pediatrics a Certificate of Merit went to Harold D. Lynch, M.D., and W. D. Snively, Jr., M.D., Evansville, and W. E. Henrickson, M.D., Poplar Bluff, Missouri, for their exhibit on "The Submarginal Child."

### NAMED G. P. DELEGATE

Lester D. Bibler, M.D., Indianapolis, was named delegate from the Section on General Practice to the A.M.A. House of Delegates, succeeding Paul A. Davis, Akron, Ohio.

### HONOR I.S.M.A. SECRETARY

James A. Waggener, executive secretary of Indiana State Medical Association, was named secretary-treasurer at the Tenth Annual Con-

ference of Presidents and Other Officers of State Medical Associations.

Mr. Waggener was also named to the American Medical Association Public Relations Advisory committee.

### THEY WERE THERE

Hoosier doctors registered at the convention included: Robert L. Armington, Anderson; Milton L. Bankoff, Michigan City; P. A. Boyer, Jr., Indianapolis; Frances T. Brown, Indianapolis; Carl A. Bunde, Indianapolis; Stanley M. Casey, Huntington; R. L. Conklin, Elkhart; John A. Davis, Flat Rock; H. W. Eikenberry, Indianapolis; C. F. Frankowski, Whiting; E. A. Garland, Evansville; W. H. Howard, Hammond; Eli S. Jones, Hammond; J. G. Kidd, Sr., Roann; W. R. Kirtley, Indianapolis; Hugh A. Kuhn, Hammond; James L. Lamey, Anderson; E. Everett Lefforge, Veedersburg; Hamlin B. Lindsey, Washington; James Z. Logan, Richmond; Henry G. Nester, Indianapolis; J. M. Paris, Jr., New Albany; Joel A. Peterson, Lafayette; L. P. Van Rie, Mishawaka; T. F. Schlaegel, Jr., Indianapolis; Wm. H. Scoins, Fort Wayne; M. E. Whitlock, Mishawaka; Richard P. Yoder, Bluffton; Walter C. Bond, Clay City; Henry Bopp, Jr., Terre Haute; Ralph W. Bruner, Jeffersonville; Philip T. Holland, Bloomington; Joseph M. Siekierski, Griffith; Tyler J. Stroup, Indianapolis; Lavon D. Bechtol, Morton Grove, Illinois; Carl H. Bendler, Gary; Lester D. Bibler, Indianapolis; Floyd A. Boyer, Indianapolis; Ettor A. Campagna, East Chicago; Alfred T. Chappel, Franklin; K. L. Craft, Indianapolis; L. A. Crandall, Jr., Elkhart; C. S. Culbertson, Jr., South Bend; T. H. Ebbinghouse, Richmond; James B. Hammond, Indianapolis; Edmond J. Harris, Muncie; Verne K. Harvey, Washington, D. C.; A. M. Hasewinkle, Fort Wayne; Theodore R. Hayes, Muncie; Milton Herzberg, Clinton; G. W. Irwin, Jr., Indianapolis; Wm. A. Miller, Hagerstown; F. Bruce Monroe, Crown Point; Frank H. Neukamp, Connersville; John H. Nill, Fort Wayne; Charles J. Rothschild, Fort Wayne; Cleon M. Schauwecker, Greencastle; Herbert A. Schiller, South Bend; Richard K. Schmitt, Columbus; Herbert N. Smith, Brookville; M. C. Snyder, Richmond; Daniel D. Stiver, South Bend; L. R. Studebaker, LaGrange; James H. Stygall, Indi-

anapolis; George A. Vail, Lawrenceburg; J. R. Weber, Fort Wayne; C. G. Weigand, Indianapolis; Elmer S. Zweig, Fort Wayne; Billie D. Bichacoff, Fort Wayne; Lee Brayton, Indianapolis; James C. Brown, Valparaiso; Ko Kuei Chen, Indianapolis; Elmer T. Cure, Muncie; Charles F. Deppe, Franklin; Otto R. Dobbs, Greencastle; B. M. Edlavitch, Fort Wayne; Kendrick T. Edmonds, Bedford; Bert E. Ellis, Indianapolis; Wayne H. Endicott, Greenfield; Hubert M. English, Gary; Thomas I. Fountaine, Bedford; Frank M. Gastineau, Indianapolis; Greta M. Gibson, Indianapolis; Ivan Gilbert, Terre Haute; D. C. Hines, New Augusta; Sterling P. Hoffman, Sr., Fort Wayne; Paul R. Honan, Jr., Tacoma; Guy B. Ingwell, Knox; J. Kenneth Jackson, Aurora; D. M. Johnstone, Indianapolis; D. B. Kahle, Indianapolis; Harry E. Kitterman, Indianapolis; Kenneth M. Lehman, Topeka; Robert C. Little, Evansville; Wm. B. Matthew, Indianapolis; Robert D. Meiser, Huntington; Edward O. H. Mitchell, Indianapolis; Harvey L. Murdock, Fort Wayne; Cleon A. Nafe, Indianapolis; William H. Olson, Michigan City; Don S. Painter, Fort Wayne; Walter L. Portteus, Franklin; Roger R. Reed, Anderson; Walter K. Robinson, Gary; Bernard D. Rosenak, Indianapolis; Eli Rubens, South Bend; Richard Schantz, Remington; Wm. L. Sharp, Anderson; Harris B. Shumacker, Jr., Indianapolis; J. S. Slabaugh, Nappanee; John H. Warvel, Indianapolis; Charles K. Wilhelmus, Evansville; Gilbert M. Wilhelmus, Evansville; Fred M. Wilson, Indianapolis; Gerald M. Wohlfeld, New Albany; David E. Wynegar, Richmond; Jesse C. Benz, Marengo; D. G. Bernoske, Michigan City; Samuel J. Brady, Gary; G. D. Buckner, Fort Wayne; Charles N. Combs, Terre Haute; Franklin S. Crockett, Lafayette; Leo L. Diamond, Marion; John W. Ebert, Indianapolis; Alfred H. Ellison, South Bend; Paul N. Harris, Indianapolis; John T. Kemp, Michigan City; Camille H. Killian, Logansport; Edward H. Kruse, Fort Wayne; Charles L. Mahoney, Terre Haute; C. B. McFarland, South Bend; James R. Mensch, Fort Wayne; LaVerne B. Miller, Evansville; O. J. Miller, Fort Wayne; William A. Misch, Cedar Lake; Josephine F. Murphy, South Bend; Thomas R. Owens, Muncie; F. B. Peck, Indianapolis; L. F. Piazza, Michigan City; H. G. Poncher, Valparaiso; A. D. Schaaf, Jamestown; Homer B.



Shoup, Greentown; Thomas E. Slimp, Logansport; W. D. Snively, Jr., Evansville; J. M. Thompson, South Bend; Joseph J. Tyrrell, Calumet City, Illinois; Robert W. Van Bokkelen, Mooresville; John W. Visher, Evansville; A. Weinstock, Rolling Prairie; Wm. H. Zimmerman, Dublin; Joseph R. Bloomer, Rockville; Robert M. Butterfield, Muncie; Joel T. Carney, Jeffersonville; Henry Fisher, Marion; J. D. McDonald, Evansville; James M. McIntyre, Indianapolis; Roscoe L. Sensenich, South Bend; Russell W. Wood, Oakland City; J. C. Ambrose, Noblesville; Hubert M. English, Gary; R. A. Ganser, Mishawaka; Robert M. Kelsey, LaPorte; Joseph L. Larmore, Anderson; Charles F. Martin, Mishawaka; Virgil McCarty, Princeton; Stephen R. Phelps, South Bend; Loren F. Schmidt, Indianapolis; Frank M. Walerko, Mishawaka; D. K. Winter, Logansport; Ansel C. Worley, Fort Wayne; R. A. Gardner, Michigan City; Alexander Govorchin, Munster; L. W. Mueller, Fort Wayne, E. G. Moore, Gary, and Ralph E. Faucett, Indianapolis.



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## *Hoosiers in Hawaii*

When the A.M.A. convention in San Francisco adjourned, a group of Indiana doctors and their families boarded a Pan-American Clipper (top photo) to fly to Honolulu for the Summer Meeting of the Hawaii Medical Association and a fabulous mixture of science, scenery and sarongs. Below, the Hoosiers have landed and are wearing their fresh flower leis, traditional token of welcome.





Officers of Hawaii Medical Association and A.M.A. snapped by Jim Waggener (chief herder of the Hoosiers on the trip). From left to right they are: Mrs. Edith C. Bennett, executive secretary (Hawaii), Homer M. Izumi, Honolulu, delegate to A.M.A. The second photo shows Dr. Bert Ellis, Indianapolis; Walter B. Quisenberry, chairman of arrangements, Mrs. Lull and Dr. George M. Lull, Chicago, Secretary of A.M.A., W. L. Porteus, Franklin, and Alfred E. Hartwell, former Honolulu delegate to A.M.A.

The last passengers now on the ground, the Hoosiers get their first sample of native dancing. Beautiful island dancers perform the graceful hulas which have helped make the island famous.





## *... and they go to a Luau*

For the 68 Hoosiers who went on to Hawaii from San Francisco, the trip was a panoramic digest of all the exotic beauty and quaint history which the travel service had promised. Scenic highlights of Oahu—palaces and rice paddies, plantations and temples, Schofield Barracks and Pearl Harbor—were visited in an all-day motor tour. The residential districts of Honolulu, the University, a drive circling Mt. Tantalus, a visit to Punchbowl Crater were on another day's agenda.

Scientific sessions were held in the Mabel L. Smyth Memorial Building with Dr. Nils P. Larsen, president of Hawaii Medical Association, presiding. Leading physicians and surgeons of Hawaii and several guest speakers and panelists from the United States were on the program.

Ample time was provided for shopping tours

and the Hoosier group came home with grass skirts, leis, sarongs, Aloha shirts, muumuus, and a variety of handcrafted articles.

Several members of the party stayed over for trips to the islands of Kakuai and Hawaii.

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**Indiana doctors who remained in the United States, taking the trip to Banff and Lake Louise, and who have any good photographs of that trip might like to share them with JOURNAL readers. Your prints will be returned without damage.**

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Outstanding experience for many in the party was the luau—a traditional lavish feast of native foods. Garbed in native dress the Hoosiers ate Kalua pig, lomi salmon, poi, chicken luau, yams, Hawaiian onions, dry fish and pineapple. Native musicians, some Hawaiian, others Tahitian or Samoan, furnished entertainment and music for dancing.

**Members of the Indiana group, below, enjoy their own private party in the Japanese Tea House. They wore native dress, checked shoes upon entering, and sat on the floor to eat the native dishes which were served.**



## Letter to the Editor

Thomas B. Noble, M.D.  
19 West Fifty Sixth St.  
Indianapolis 8, Indiana

June 23, 1954

Letters to the Editor,

The enclosed part of a long accumulation of material gathered from watching this business of "accreditation" in action is submitted to THE JOURNAL, herewith.

I think we need real protection, and it seems that the safest way is through protective legislation.

It will take some time to work out of the morass we have been led into; but it is worth the working, I believe.

I understand that this mess cannot be part of THE JOURNAL's editorial policy, so the submission to this department in this short form.

Sincerely,  
Thomas B. Noble

### THE OTHER SIDE OF THE MIRROR

I have been engaged in surgery since 1917. That year I was attached to the Royal Army Medical Corps in Belgium.

There were no rules to help the young beginner, or the older seasoned veteran, as new weapons made new injuries. Voluntary medical meetings were the expression of an avid and universal search for answers to problems of life, death and public health.

Crile came from Vlamertinghe with the hope that delicate layer suturing might hold perforated intestine in the presence of peritonitis.

Cushing, from Proven, advocated cotton pledgets in warm saline to control brain bleeding.

Chubb argued for speed and quick turnover so that some wounded roused from anaesthetic far from the casualty clearing station.

A friendly but very critical ear was extended to all who might have helpful suggestion. This

was the inherited tradition of men who practiced medicine, and were unafraid.

There have been times in the history of medicine when the stimulus of free thinking has been prohibited. Far from the courageous assurance and dignity of the men in Belgium, the restrictive effect of small minds in power has brought no affection to the memory of the ilk of Galen.

Today, are we to turn toward Galen or toward Crile and Cushing?

Before September 1953, surgeons of Indianapolis have been free to solve problems of therapy as their different and individual abilities advised. Now there are "yardsticks" prescribed in pathology, surgical technique and prognostic aim, if "accreditation is to be had." "Without accreditation, no hospital will retain its license." If a surgeon departs from the "yardsticks" he will be closed out of hospitals. He will then be driven out of practice, out of needed use to the public, and out of the means of making his livelihood.

We need to discuss the claim for and effect of these rules, both sides of the mirror; as it were.

These few of the many rules, noted in quotation marks, carry severest penalty, without appeal, if not followed explicitly.

"Ovarian cyst, simple, serous, luteal, and other non malignant types, may not be removed from women below the age of 51."

Microscopic description on chart sheet, alone, is the basis for determination of whether right or wrong was done. The following questions are some of the many that must be answered by the rule makers, first.

What is the relation between chronic pelvic congestion, due to a particular cyst, and eventual fibroid tumor, endometriosis, polyp, or adenocarcinoma? What adhesions will form, and what gut will they involve? What bearing on fertility or sterility has this cyst? What changes in other systems may come from persistence of the cyst?

Almost blind trust extended to doctors has



brought American medicine to the highest peak of that science in all history. Can American surgery be limited by microscope and remain adequate for treatment of all ovarian cysts? The answer lies in the fact that the microscopic picture of a microscopic part of an ovary cannot begin to write the history of complaint or answer the few questions mentioned.

"There are only three kinds of appendicitis; ruptured, with peritonitis; gangrenous; and unwarranted."

I had pain for four years after infectious dysentery. My father removed the appendix, and pain ceased that day. It has not returned in the more than 20 years. This experience has been so commonly seen that the trigger mechanism of its origin has been called "chronic appendicitis," "interval appendicitis," "sub-acute appendicitis," and other terms. The microscope does not show the origin or mechanism of such legitimate complaint or pathology.

Earliest acute appendicitis, brilliantly diagnosed and accurately treated by removal, may return from the laboratory dehydration technique as "appendix." That earliest congestion is not recognizable under narrow rules of procedure and does not detract from the propriety of good medicine and early appendectomy.

We are asked, "What is your present percentage of non-gangrenous appendectomies?" The needed appendectomy goes looking for a surgeon, any surgeon, whose statistics chart-wise permit this work to be done at this time.

Must the accusation of "unwarranted" or "criticized" drive us back again into drainage of appendiceal abscesses and neglected peritonitis? I saw these frequently 30 years ago; rarely now.

"Caesarean section may not be done for disproportion." Since before the days of Caesar this operation has saved lives. Today it is so safely done that its mortality is no more than usual confinement. Its postoperative morbidity, from structural damage residue, is incomparably superior to any confinement. We all know that gynecological repair of damage to uterus and perineum cannot restore a complete normal.

Caesareans eliminate gynecological cripples and spastic children; save both mother and child

from fatal toxemias; and permit families where otherwise there could be none.

If the percentage of Caesareans is more than around 2%, the hospital is criticized. Can we be sure that in that hospital so "criticized" the public health would not have been better served with a total of 10% Caesareans? Who has this answer?

"Fibroids less than one centimeter are not sufficient and acceptable reason for hysterectomy."

"There are too many suspensions."

"Collagenous replacement of uterine musculature, so-called subinvolution, is not an acceptable reason for hysterectomy."

"All hysterectomies must be preceded by D and C."

"There are too many spinal fusions for ruptured discs."

"Endometriosis is not acceptable as reason for hysterectomy, unless it has advanced to general peritoneal implantation."

"Prolapse is not acceptable as reason for hysterectomy before 51."

These dicta affect the freedom of the surgeon to use his best judgment—as is required by law. They deal with basic matters of surgical judgment that are individual with each patient. True, extravagant and voluminous "documentation" on a chart may permit the very things "criticized" most severely, if adroitly done. There is danger here. The highest plane of moral integrity does not come from alibi, bombast, verbal diarrhea, and the like.

We note in Indianapolis a disappearance of internes. It is true that any Indiana County Hospital offers a golden opportunity for a beginner to work closest with practicing doctors—and this form of preceptorship has always produced good men. Accreditation has made it impossible for such hospitals to offer their good chance for many young men who want to be good doctors.

The claim that training cannot be sufficient in the small hospitals brings to light a strange phenomenon. In Indianapolis the men permitted to teach internes do not include the men who have contributed most or any to their respective fields



in medicine. The man who has made the nation's best record in goitre surgery is not allowed to teach the internes or resident in his chosen hospital. In the field of gynecology, the man who has done most and contributed most is not permitted to teach. In orthopedics, in ENT, in obstetrics, in abdominal surgery, this is true.

Internes and residents have not been permitted to serve men who do not teach them. Out of more than 100 surgeons, 5 were chosen as acceptable teachers; and none of the 5 is known in the literature of surgery.

Does this explain the unwillingness of young men to train here?

Under the dicta that have come to us as "accreditation," doctors have to face a new four-sided jeopardy; loss of "staff privilege" from chart "criticism"; need to alter therapy to conform to new "yardsticks," not in agreement with common judgment; the chance of malpractice action because of incomplete and inadequate treatment understood as such by the doctor; and, already seen, the return to a dog-eat-dog kind of ethics where one can get away with what another cannot, simply because he holds office.

Above most men, American doctors have been constructively critical of all they do. Their habit of self-analysis has looked into all aspects of medicine; its science, finance, mortality and morbidity factors, and the transmission of its knowledge to the future.

We have worked toward less mortality, less morbidity, better preventive medicine; and these mean "raised standards" in the best sense.

Claiming to raise standards under the accredi-

tation system, a new philosophy of compulsion and exclusion has come into sight.

The American plan of inclusive medicine, open to all doctors, has made American public health the standard of the world. The presumed poor doctor has the company of his wiser colleagues in the American Medical Way. Did it end as of September, 1953?

Compulsion, restriction, limited classification and certification are foreign to the picture of American and Indiana Medicine, as they have meant so much to the public health.

I believe the bright side of the mirror is the record of what has been done for the public health and for the advance of scientific knowledge here under the completely free and competitive system of American Medicine that permitted a patient to choose his own doctor.

That patient, directly or indirectly, has a vested right in all hospitals in Indiana. Tax support is universal in some manner, and the patient pays the tax as well as his hospital bill.

The dark side of the mirror, the exclusion of most doctors from hospitals by the action of the restrictions against the practice of long-established good principle, is a destructive return toward dormant medicine. The public loses.

In Indiana, the Supreme Court has held that a licensed physician cannot be denied his right to treat his patient in the county hospital. This, I submit, is a dignified protection to public health and should be extended by the next Legislature to cover all hospitals that in any way have tax advantage. Indiana Medicine needs to be free, because far above 90 percent of Indiana physicians are worthy, and to exclude any of them is unthinkable.  
—T. B. N.

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## Deaths . . .

**Phillip L. Mull, M.D.**, 81, died in Washington County Memorial Hospital, Salem, June 10. He had been retired and living in Louisville for several years. Dr. Mull practiced in Oldenburg for many years and taught in Mississippi and at the Louisville School of Medicine. He was a senior and Fifty Year Club member of the Indiana State Medical Association.

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**James E. Keeling, M.D.**, 86, Waldron, died in Major Hospital, Shelbyville, June 26, where he had been a patient for two months. He had been ill for six months. Dr. Keeling was Shelby county's oldest practicing physician at the time of his retirement last January. A native of Geneva, he established his practice there following graduation from the Medical College of Indiana. He began the practice of medicine in Waldron in 1903. Dr. Keeling served as Shelby county health commissioner from 1939 to 1949. He was a senior member of the Shelby County Medical Society, and the Indiana State Medical Association and an associate member of American Medical Association. He was also a Fifty Year Club member of I.S.M.A. Dr. Keeling was the father of Forrest E. Keeling, M.D., Portland, who has been in service for the last two years with the Army in Germany.

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**Harley S. McKee, M.D.**, Greensburg, died June 18 in a Rochester, Minnesota hospital where he had been a patient for several weeks. He was 75.

Dr. McKee taught for several years before entering Illinois Medical College at Chicago from which he was graduated in 1907. He established his practice at New Point and moved to Greensburg in 1920. Dr. McKee had been active in both medical and civic affairs during the years he lived in Decatur county. He had served the Decatur County Medical Society as president and secretary, had been county coroner, secretary of

Greensburg board of health and for the last 20 years had been county health officer. He had lodge, service club and church affiliations.

Dr. McKee was a senior member of Indiana State Medical Association and had served as a member of the House of Delegates several times.

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**Marshall P. Hollingsworth, M.D.**, 92, died June 16 in the home of his son at Princeton where he had been ill for several months. He had been in retirement since 1948 after having practiced medicine for 56 years in Princeton. He was a native of Marion county and an 1891 graduate of the Medical College of Indiana. He served as resident physician at Indianapolis City Hospital for one year.

During his long career in Gibson county, Dr. Hollingsworth had served as medical examiner during the Spanish-American War, World War I and II, had been county coroner for eight years, served as medical advisor to the Southern Railway for 35 years and for many years was an insurance examiner. He had interests in several business enterprises, among them a building and loan company which he had organized 45 years ago.

Dr. Hollingsworth was a member of Gibson County Medical Society, and a senior and Fifty Year Club member of Indiana State Medical Association.

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**Walter McBeth, M.D.**, 78, Royal Center physician for many years, died in his home June 25. He had been ill for several years. Dr. McBeth was a native of Monticello, a graduate of the Medical College of Indiana in 1901, and practiced in Burnettsville for 20 years before moving to Royal Center in 1922. He served as a captain in the medical corps during World War I. He held membership in several lodge and fraternal organizations. Dr. McBeth was a former member of Cass County Medical Society, the Indiana State and American Medical Associations.

**Merton A. Farlow, M.D.**, 71, died July 3 after a brief illness in Methodist Hospital, Indianapolis. A retired lieutenant-colonel in the army, he had been on the staff of Central State Hospital, Indianapolis, for 15 years. Dr. Farlow was a native of Rushville and a graduate of Indiana University School of Medicine in 1908. He served in the United States Army for 21 years.

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**Francis A. Malmstone, M.D.**, Griffith, died in the American Hospital in Paris, France July 1. He was touring Europe with members of his family when he was stricken with a heart attack on June 13.

Dr. Malmstone was born near Lake Station, a small village which became East Gary. He taught school in Montana and Indiana for a number of years before entering the Chicago College of Medicine and Surgery from which he was graduated with a medical degree in 1914 at the age of 37. He served a year's internship at the Oak Park Hospital and moved to Griffith in 1915. He had practiced there for 39 years at the time of his death.

Dr. Malmstone was a senior member of Lake County Medical Society and the Indiana State Medical Association and an associate member of American Medical Association.

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**Isidor J. Raphael, M.D.**, 56, Evansville pediatrician, died in St. Mary's Hospital in that city July 4. He failed to recover after a tooth extraction and entered the hospital June 15. His illness was then diagnosed as acute monocytic leukemia.

Dr. Raphael was a native of Evansville, received his medical degree from Rush Medical College, Chicago, in 1923, interned at Buffalo City and Ernest Wende Hospitals, Buffalo, and served his residency at New York Seaside Hospital for Children. He also served as clinical assistant at New York Postgraduate Hospital before returning to Evansville to establish his practice. He served as a major in the medical corps during World War II.

Other than his medical practice Dr. Raphael's principal interest was the Evansville Philharmonic orchestra. He was a past president of the Philharmonic board.

He was a member of the board of directors of the Vanderburgh County Medical Association, and was a member of Indiana State and American Medical Associations.

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**Joseph D. Seybert, M.D.**, 61, Kendallville, died in Methodist Hospital, Indianapolis, July 5 after a long illness. He was a native of LaGrange county, received his medical degree from Indiana University in 1921, and successively served his internship at Harper Hospital, Detroit, and Indianapolis City Hospital, and was a staff member at Central State Hospital before establishing his practice in Kendallville in 1923. He had been Noble county coroner and a member of the county council. Dr. Seybert served with the Indiana National Guard on the Mexican border and in 1917 enlisted in the navy, serving throughout World War I.

He was a member of Noble County Medical Society, the Indiana State and American Medical Associations and had many fraternal and civic club affiliations.

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**Charles Elwood Linton, M.D.**, who had practiced medicine for 50 years in Medaryville and was the town's only doctor, died July 5 in Holy Family Hospital, LaPorte, where he had been taken a few days earlier from Hines Hospital, Hines, Illinois. He had been in ill health for several months.

Medaryville paid tribute to him August 25, 1953 when several thousand patients and former patients and their families gathered for celebration of "Dr. Linton Day", a part of the town's Centennial observance.

Dr. Linton was born in Carroll County. He received his medical degree from the Medical College of Indiana in 1902 and went to Medaryville in 1904. He had served in the Spanish-American War.

Dr. Linton served as president of Pulaski County Medical Society for 38 years, as society secretary for six years and had been a member of the House of Delegates of Indiana State Medical Association of which he was a senior member. He was also a member of American Medical Association, a member of high Masonic orders, and a 50-year member of the Knights of Pythias. His survivors include a son, Charles D. Linton, M.D., Walkerton.

**Arvin A. Henderson, M.D.**, 66, Ridgeville physician, died July 8 in Jay County Hospital, Portland, where he was taken after sustaining injuries in an automobile accident June 21.

Dr. Henderson was born in Summersville, Kentucky, and was graduated from the University of Louisville School of Medicine in 1911. He returned to his hometown to practice for several years and in 1919 established his practice in Ridgeville. Dr. Henderson was president of the Eighth District Medical Society at the time of his death and had always been active in the Randolph County Medical Society. He was a member of Indiana State and American Medical Associations. In addition to his professional activities, Dr. Henderson had widely diversified interests. He was a leader in the Randolph County Council of Christian Education, active in his own church, lodge and service clubs. He was an ardent bowler and golfer.

Survivors include two sons, Dr. Arvin Henderson of Oakland, California, and Dr. Ramon Henderson, Muncie.

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**Blanchard B. Pettitjohn, M.D.**, retired Indianapolis physician, died in his home July 9. He was 76 years old and had been a life resident of Indianapolis. Dr. Pettitjohn was graduated from the Medical College of Indiana in Indianapolis in 1901. He retired from active practice in 1951. He was a former member of the local, state and national medical associations, and was a Fifty Year Club member of Indiana State Medical Association.

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**James M. Hicks, M.D.**, 47, Huntington physician, died June 16 in McDonald Hospital, Warsaw, of a self-inflicted gunshot wound. He had been staying at nearby Secrist lake. Dr. Hicks was born in Huntington, received his degree in medicine from New York Medical College, Flower and Fifth Avenue Hospitals, New York, in 1935, and interned at Muhlenberg Hospital, Plainfield, New Jersey. He served as a captain in the medical corps during World War II. He had also practiced in Warsaw and in Zanesville, Ohio.

**John A. Little, M.D.**, 85, former Logansport physician, died June 7 in Burbank, California, of cerebral thrombosis. He had gone to California from his home in Evanston, Illinois, for a visit. Dr. Little was born near Logansport. He received his medical degree from Rush Medical College, Chicago, in 1898 and immediately began the practice of medicine in Logansport where he remained for almost 50 years. On his retirement he went to Evanston. Dr. Little was one of the early promoters of Gary and the realty firm of Little and Stevens still owns business properties there. Dr. Little was one of the organizers of the Cass County Public Health Association and was reported to be among the first to use anti-toxin in the treatment of diphtheria. He was a member of the Indiana State Medical Association, having received his 50-year certificate, and of the American Medical Association.

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**Lorenzo Hooten, M.D.**, 83, who practiced medicine for nearly 50 years in Ripley and Switzerland counties, died June 13 in his home in Cross Plains. He had been ill for three years. Dr. Hooten taught school in southern Indiana until he was 30 when he entered Louisville Medical College where he received his degree in 1907. He practiced in Bennington for 12 years, then moved to Cross Plains where he had been in practice until forced to retire by ill health.

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**Edwin Stanton Knox, M.D.**, 84, retired Indianapolis physician, died June 20 in the Gorge Nursing home at French Lick where he had been ill for several months. Dr. Knox received his medical degree from the Medical College of Indiana in 1895. He taught from 1901 until 1922 at Indiana University School of Medicine, serving last as associate professor in medicine. He also served for some time as Marion county deputy coroner.

Dr. Knox lived at 4315 Central Avenue, Indianapolis, before going to the Mineral Springs Hotel in Paoli for residence several years ago. He was a member of the Masons and Shrine in Indianapolis. Dr. Knox was a member of the Fifty Year Club of Indiana State Medical Association, and a member of Indianapolis Medical Society.





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# NEWS NOTES—from State and Nation

## **Dr. John H. Warvel Is Diabetes Association Governor**

Dr. John H. Warvel, Indianapolis, has been named a governor of the American Diabetes Association for Indiana and has been reappointed to the national Committee on Detection and Education of the American Diabetes Association. Announcement of both appointments was made by national headquarters in New York.

Dr. Warvel will assist in making plans for Diabetes Week, November 14-20, when the annual Diabetes Detection Drive will be renewed this year to aid in the detection of many unsuspected cases of diabetes.

Dr. Warvel was a pioneer in the use of insulin for controlling diabetes. He was with the Lilly research department for 29 years.

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**Drs. Dewitt Brown and Earl Mericle**, Indianapolis, acted as examiners for the American Board of Psychiatry and Neurology at the May examinations in Chicago.

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**Dr. H. Clark Boyd**, formerly of Ann Arbor, Michigan, has moved to Terre Haute and is now associated with Dr. A. W. Cavins in the Department of Obstetrics and Gynecology of the Associated Physicians and Surgeons Clinic.

Dr. Boyd has been practicing obstetrics and gynecology in Warren, Pennsylvania. He is a graduate of the University of Michigan and the Faculty of Medicine at McGill University and was recently released from the army after having served as lieutenant-colonel and colonel during World War II and the Korean War. During the latter conflict, Dr. Boyd was Chairman of the Department of Surgery and Chief of the Obstetrical and Gynecological Section, Murphy Army Hospital, Waltham, Massachusetts. He is a Fellow of the American College of Surgeons, a Fellow of the American Academy of Obstetrics and Gynecology and a Diplomate of the American Board of Obstetrics and Gynecology.

**Dr. Charles F. Smith**, a native of Kokomo and graduate of Indiana University School of Medicine in 1946, has been associated since February 1 with Dr. Raymond C. Beeler, 712 Hume Mansur Building, Indianapolis. Dr. Smith served internship and residency at Indianapolis General Hospital and from 1950 until January, 1954, was a fellow in radiology at the Mayo Clinic. During that period he obtained an M.S. in radiology from the University of Minnesota. He is certified by the American Board of Radiology.

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**Dr. Kenneth L. Craft**, Indianapolis, spoke on "Diagnosis of Nasal Allergy" at the May meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology held at Bedford Springs, Pennsylvania.

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**Among recent grants** made by Eli Lilly and Company to support research projects in universities and hospitals were those to the Fifth Congress of the International Society of Hematology and to Indiana University for establishment of a culture collection of algae under the supervision of Dr. Richard C. Starr, assistant professor of botany.

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A group of 21 members of **Lake County Medical Society** spent June 14 and 15 in Detroit where they visited Parke, Davis & Company offices and plant. Particular interest was shown in the firm's 53-year-old research building, the first commercial building erected solely for scientific research.

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**Dr. Lloyd A. Vogel, Jr.**, is associated with Dr. Francis L. Land, 116 West Rudisill Boulevard, Fort Wayne, in the general practice of medicine and surgery. He has just completed a one year's internship at Lutheran hospital. Dr. Vogel is a native of Des Moines, Iowa, but has



lived most of his life in Fort Wayne. He received his M.D. from Indiana University School of Medicine in 1953.

**Dr. J. T. How**, Lakeville, recently received his 50 year Masonic pin in a ceremony in the Lakeville lodge where he has held many offices. Dr. How is a Fifty Year Club member of Indiana State Medical Association, having practiced in Lakeville since 1902.

**Dr. George M. Buehler**, Jeffersonville, has moved into new offices at 414 Wall Street, according to a recent announcement.

**Dr. Eugene Gillum**, native of Union City and 1953 graduate of Indiana University School of Medicine, has opened an office to practice general medicine in quarters formerly occupied by the late Dr. John M. Engle, in Portland. Dr. Gillum served in the Pacific theatre during World War II with the U. S. Army Air Corps. He has just completed an internship at Indianapolis General Hospital. His offices will be in the Hawkins Building and he and Mrs. Gillum are residing at 136 South Park Street, Portland.

**Dr. Floyd L. Rheinheimer**, who recently completed an internship at Indianapolis General Hospital, has purchased the H. S. Snyder building on Main Street in Milford and has established an office for general practice. Dr. and Mrs. Rheinheimer will use the second floor of the new building for a residence.

**Dr. Robert A. Cornell**, Crawfordsville, underwent major surgery recently in Indianapolis for a back injury sustained in a parachute drop in Europe. The injury had become aggravated, requiring surgery and several weeks rest.

### **Urological Association Offers Annual Awards**

The American Urological Association offers an annual award of \$1,000—first prize of \$500, second prize \$300, and third prize \$200—for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than 10 years and to men in training to become urologists.

The first prize essay will appear on the program of the American Urological Association to be held in Los Angeles, May 16-19, 1955.

Details may be obtained from William P. Didusch, Executive Secretary, 1120 North Charles Street, Baltimore, Maryland. Essays must reach him by January 1, 1955.

**Dr. Theodore C. Person** has recently moved to Veedersburg from Peru and has opened an office for the general practice of medicine. He is a native of Youngstown, Ohio, a graduate of I. U. School of Medicine in 1950 and interned at Allentown Hospital, Allentown, Pennsylvania. He served three years in the Army Air Force during World War II, most of that time in the China-Burma-India theatre.

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### Named President-Elect of College of Chest Physicians

Dr. James H. Stygall, Indianapolis, was elected president-elect of the American College of Chest Physicians at the recent meeting of the College in San Francisco. He will assume the presidency in June, 1955.

Dr. Joe Ebbinghouse, formerly of North Manchester, who received his degree in medicine from I. U. June 14 has enlisted in the Air Force and will intern at the North Carolina University Medical Center at Chapel Hill.

Dr. B. E. Sugarman has moved to his new building on Main street in French Lick. Of block construction with a sandstone front, the building has seven rooms and a utility room where central heating and air-conditioning units are housed. Included in the plan is a 2-bed room for emergency patients and a modern drug room. Parking space for patients' cars and a covered ambulance entrance have been provided.

Dr. Joe M. Black, Seymour, is now practicing in his new modern office building at 502 West Second street. The one-story structure is air-conditioned and has soundproof rooms.

Dr. F. E. Keeling, who has been serving as a colonel with the U. S. Army Medical Corps in Germany for more than two years, plans to resume his practice in Portland September 1. He was scheduled to leave Germany early in July. His offices will be at 116 West Walnut Street, Portland.

Dr. William H. Robinson, Madison native, has opened an office for general practice of medicine in Mitchell at 124 North Sixth Street. He is an Air Force veteran, graduate of Indiana University School of Medicine, interned at Georgia Baptist Hospital, Atlanta, and practiced one year in East Atlanta. Mrs. Robinson is a native of Mitchell.

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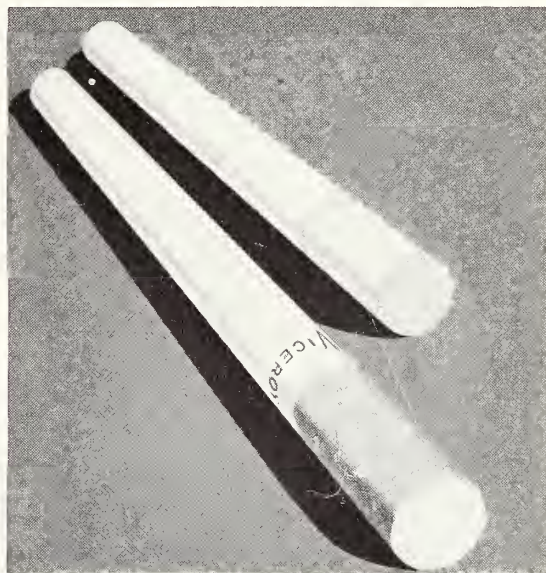
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### Topic for Caleb Fiske Prize Announced

"Modern Developments in Anesthesia" is the subject selected by the Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society for the annual essay competition sponsored by the group.

The Caleb Fiske Prize contest is believed to be the oldest medical essay competition in the United States. Trustees offer \$250 for a type-written, double-spaced, essay which does not exceed 10,000 words.

For information write the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Named by county commissioners of Dubois county to fill the unexpired term of his father, Dr. W. D. Bretz, as county health officer, **Dr. John D. Bretz**, Huntingburg, will hold that position until December, 1957.

Two resident physicians in radiology have been added to the Caylor-Nickel Clinic, Bluffton. **Dr. Glen M. Jones**, Harlingen, Texas, and **Dr. Sherman H. Merritt**, Snyder, Texas, have begun their residencies. Both are Baylor University graduates and have been in private practice.

**Dr. G. P. Backer**, who has been in practice in Ferdinand for the last two years with his father, Dr. H. G. Backer, has accepted a three year residency in radiology at the Indiana University Medical center. He was recently married to Miss Barbara Yeager, Richland, who is completing her last year in medicine at I. U.

An office for the general practice of medicine was opened at 1743 Shelby Street, Indianapolis, July 6, by **Dr. George B. Keenan**. Dr. Keenan was graduated from Indiana University School of Medicine in 1953 and has just completed his internship at Methodist Hospital.



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**Dr. Howard A. Bosler**, Waterford Mills physician and president of the Goshen hospital staff, was recently awarded a certificate of citation by Manchester College from which he was graduated in 1923. The citation was for his outstanding work as a medical missionary in Nigeria, West Africa from 1931 to 1950. He served as administrator and medical director of Garkida leprosarium, one of the largest in Africa. In 1950 he was made an honorary officer of the Order of the British Empire by the King in recognition of his service.

**Dr. L. Paul Hart**, Evansville, physician and surgeon, has been named medical director for the International Harvester plant in that city. He succeeds Dr. Karl Hefti who died May 28. Dr. Hart, an I. U. graduate in 1936, was in general practice in Evansville until 1941 when he was commissioned in the Army Medical Corps. He practiced again in Evansville after his return from overseas duty, then went to St. Louis for postgraduate work in surgery. He has been certified by the American Board of Surgery. Dr. Hart's offices are at 125 South Second Street, Evansville.

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**Dr. Andrew Offutt to  
Succeed Dr. L. E. Burney**

Dr. Andrew C. Offutt, native of Greenwood, has been named to succeed Dr. Leroy E. Burney as state health commissioner and secretary of the Indiana State Board of Health. Dr. Offutt was selected by the state board from a large list of applicants and his appointment approved by the Governor. He will assume his duties September 1 when Dr. Burney returns to active duty in the U. S. Public Health Service as assistant surgeon-general.



The new commissioner is a graduate of Indiana University School of Medicine and served in the army 10 years. He has been on the health board for three years, serving as director of the bureau of preventive medicine. He resides at 750 North Campbell Avenue, Indianapolis.

**Dr. Roger C. Smith** has opened offices for the practice of internal medicine in the Medical Center building, Fort Wayne. He recently completed a three year residency at Mayo Clinic. Dr. Smith formerly was in practice in New Haven with his father, Dr. G. A. Smith, and his brother, Dr. Richard B. Smith. He received his degree from Indiana University School of Medicine in 1944, interned at Grace Hospital, Detroit, and served in the Army Medical Corps two years. Dr. Richard Smith left July 1 to start a three-year residency in internal medicine at the Mayo Clinic after which he will resume his practice in New Haven.

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# News from the County Societies

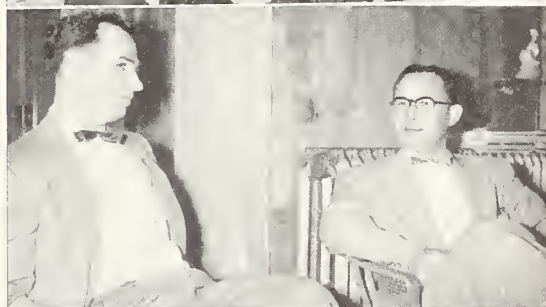
Dubois County Medical Society members held their final meeting until fall in the Jasper American Legion clubhouse on June 10. The eight members present held a panel discussion on "Insurance, Patients and Hospitalization." Dr. A. B. Scales, Huntingburg, was elected to active membership. Until recently he had served as commanding officer of the hospital at Fort Benjamin Harrison. The next meeting will be held October 14 in the Jasper Legion home.

Dr. E. M. Dewhirst, Danville, Illinois, was the guest speaker at the June 17 meeting of **Montgomery County Medical Society** in Culver Union Hospital, Crawfordsville. He presented a paper on "Poliomyelitis, Diagnosis and Management" to the 25 members who attended the dinner meeting.

At a brief business meeting members voted to give requested assistance to the Civil Air Patrol and voted into membership Dr. Wesley Eugene Shannon. The next meeting will be held September 16 at 7 o'clock in the Culver Union Hospital.

Members of **Perry County Medical Society** were entertained by the Auxiliary June 20 at a fried chicken picnic supper at the home of Dr. and Mrs. D. L. Lashley, Tell City. Mrs. Lash-

Noble County Medical Society members are pictured, right, at a recent meeting. Reading from top to bottom and left to right are Drs. Quentin F. Stultz, Ligonier; Frank W. Messer, Kendallville, secretary; and Kenneth D. Sueary, Avilla, president; B. H. Pulskamp, Wolcottville; A. L. Fipp, Rome City; and James R. Roth, Wolf Lake; Paul L. Webster, Ligonier, and Robert E. Bryan, Kendallville; Herman Hepner, Kendallville; James B. Schutt, Ligonier, and E. D. Mattmiller, Avilla; Justin R. Nash, Albion; Carl F. Stallman, Kendallville; I. H. Lawson, Kendallville, and Dr. Pulskamp.





Jackson and Jennings County Medical Societies members below are, left to right: Drs. D. L. Adler, H. E. Miller, W. B. Sigmund; C. A. Weithoff, H. R. Baxter, and W. B. Sigmund; D. J. Cummings and G. H. Kammen; J. E. Shields and J. M. Black; R. W. Keyes, administrator of hospital; Dr. Weithoff, and William D. C. Day; Dr. Kammen and D. W. Matthews; William Scharbrough and J. H. Green.



ley, president, announced that no Auxiliary meetings would be held during the summer.

**Shelby County Medical Society's** June 23 meeting was held at the home of Dr. and Mrs. Paul Tindall, Shelbyville. Twenty-five doctors and their wives enjoyed a picnic supper. At a business meeting the society awarded two \$100 scholarships to high school graduates for use in nurse's training courses. The next meeting of the Shelby County Society will be on September 8.

A business meeting of **Tippecanoe County Medical Society** was held June 8 in the 40 & 8 Clubhouse, Lafayette. Forty-three members and six guests were present. A number of routine matters were acted upon, and reports of Shick tests among county school children were given. Dr. Gordon Thomas reported on the Ninth District Medical meeting, stating that a liaison committee with Blue Shield had been formed.

Two applications for membership were approved and Drs. William L. Foust and Robert W. Kohne were accepted as members.

The summer picnic of the society was held on July 15 at Lake Shafer.



Several members of Delaware-Blackford County Medical Society, above, were photographed at an April 20 meeting of the group. They are, left to right, Drs. William B. Adams, president-elect, Thomas M. Brown, president, and W. E. Coyalt, secretary; Orville A. Hall, E. H. M. Clauser, ISMA Executive Committee member, and T. D. Hayes, Eighth District concilor, all of Muncie.

### Psychiatry and the Practice of Medicine

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—WILLIAM C. MENNINGER, M.D.  
in "Psychiatric Bulletin", p. 19,  
Winter, 1953-1954 (Vol. IV, No. 1)



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# The *Journal*

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## The A B C's of Fluid Balance

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*Evansville*

### PREFACE

**M**UCH OF THE CONFUSION which surrounds the immensely important subject of fluid balance is dissipated if the subject is approached from the clinical rather than from the biochemical viewpoint. Additional clarity is achieved if each instance of disturbed fluid balance is studied systematically with a view to determining which of the several facets of the body fluids are in imbalance and to what extent. Provided with this information, the clinician will find that parenteral therapy designed to correct fluid imbalance is no hit or miss affair, but rather an orderly process which at best will produce dramatic results and at worst will do no harm.

This article was not prepared to furnish comprehensive information or even to provide a working knowledge. Rather, its purpose is to help orient the clinician with respect to the basic concepts and principles involved in clinical fluid balance, and to provide him with "knowledge pegs" upon which to hang the multitude of facts concerning the subject that can be gleaned from an understanding study of the rich clinical literature.

### BODY FLUIDS

**Fig. 1. Human extracellular fluid resembles the Cambrian seas.**

The extracellular fluid of primitive aquatic creatures was the ocean in which they spent their lives, for they possessed no extracellular fluid of their own. Before our remote marine ancestors could come ashore to enjoy what Gamble has termed their "Paleozoic Palm Beach" or their "Eocene Eden," it was necessary for them to bring, as it were, a parcel of their oceanic environment with them. Refer to Figure 1. This they did in the form of their extracellular fluid.



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\* Medical Department, Mead Johnson & Company.



**TABLE I.—Laboratory Values of Importance in Fluid Balance.**

Red blood cell count	Men: 4.5-6.0 million/cu. mm. Women: 4.3-5.5 million/cu. mm.
Hemoglobin concentra- tion	Men: 14-16 Gm./100 ml. Women: 13-15 Gm./100 ml.
Hematocrit	Men: 45-47% Women: 40-42%
Plasma sodium (Na <sup>+</sup> )	137-147 mEq./L.
Plasma potassium (K <sup>+</sup> )	4.0-5.6 mEq./L.
Plasma calcium (total) (Ca <sup>++</sup> )	4.5-5.8 mEq./L.
Plasma magnesium (Mg <sup>++</sup> )	1.4-2.4 mEq./L.
Plasma bicarbonate (HCO <sub>3</sub> <sup>-</sup> )	25-29 mEq./L.
Plasma chloride (Cl <sup>-</sup> )	98-106 mEq./L.
Plasma phosphate (inorganic) (HPO <sub>4</sub> <sup>-</sup> )	1.7-2.6 mEq./L.
Plasma organic acids	4-8 mEq./L.
Plasma proteins (proteinate <sup>-</sup> )	14.6-19.4 mEq./L.
Normal ratio of car- bonic acid:base bicar- bonate (H <sub>2</sub> CO <sub>3</sub> :BHCO <sub>3</sub> )	1.35:27 (roughly 1:20)
Carbon dioxide (CO <sub>2</sub> ) combining capacity of the plasma in volumes per cent	Adults: 53 to 75 vols. % Children: 40 to 55 vols. %
in mEq. per liter	Adults: 24.1 to 34.1 mEq./L. Children: 18.2 to 25 mEq./L.
Normal limits of plasma pH	7.35-7.45
Normal limits of urine pH	4.7-8.0

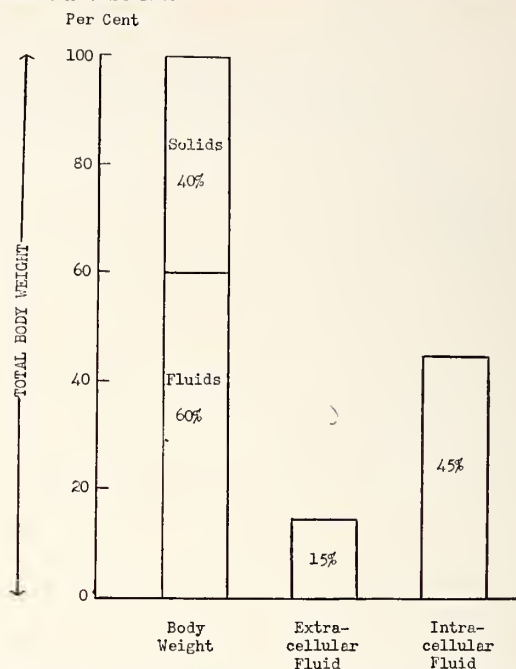
The above figures were adapted from "Water, Electrolyte and Acid-Base Balance." (Weisberg, H. F.: Water, Electrolyte and Acid-Base Balance, Baltimore, The Williams & Wilkins Company, 1953.)

The composition of this fluid has been so faithfully preserved over the ages that today human extracellular fluid closely resembles in its composition the Cambrian seas of the remote geologic era when life made its first landfall, rather than the more concentrated oceanic waters of today.

Chemists refer to water as the "universal solvent." In the body, as in the chemical laboratory, water is indeed the universal solvent. It provides the necessary environment for the continuous and varied life processes. The water of the body and its chemical substances comprise the body fluids. According to Weisberg, these amount to approximately 50 to 73 per cent of body weight for adult males and 44 to 65 per cent for adult females. The range for infants is 70 to 83 per cent of body weight. Chart I shows the average distribution of body weight between fluids and solids.

The body may be visualized as having two reservoirs of body fluid:

Note: The normal range of all laboratory values referred to in the text are presented in Table I.

**CHART I. Distribution of Body Weight Between Fluids and Solids.**

Adapted from: Moyer, C. A.; Fluid Balance; A Clinical Manual, Chicago, The Year Book Publishers, Inc., 1952; and Weisberg, H. F.: Water, Electrolyte and Acid-Base Balance, Baltimore, The Williams and Wilkins Company, 1953.

The first is the *extracellular* reservoir which includes all the body fluids outside the cells. It is divided into two categories—the *extracellular extravascular fluid*, commonly known as the *interstitial fluid*, and the *extracellular intravascular fluid*, commonly known as the *plasma*. The extracellular fluid comprises about 14 to 23 per cent of the body by weight for the adult male, and 14 to 20 per cent for the adult female. The extracellular fluid comprises about 25 to 33 per cent of body weight for infants.

The second great reservoir of fluid is the *intracellular* reservoir, or the fluid contained within the cells. This is the larger of the two great reservoirs, and it comprises 36 to 50 per cent of the body by weight for the adult male, and 30 to 45 per cent for the adult female. The intracellular fluid comprises 45 to 50 per cent of body weight for infants. Due chiefly to limitation of our present knowledge, we do not divide the intracellular fluid into extravascular and intravascular categories. Instead, we group the fluid of the cells that are contained within the blood vessels and outside the blood vessels into one large category, that of the intracellular fluid.

Fig. 2. The C.&E.L. road diesel weighs 230,000 pounds; has 1,500 horsepower.



Fig. 3. The Eastern Airlines "Falcon" weighs 45,000 pounds; has 4,800 horsepower.



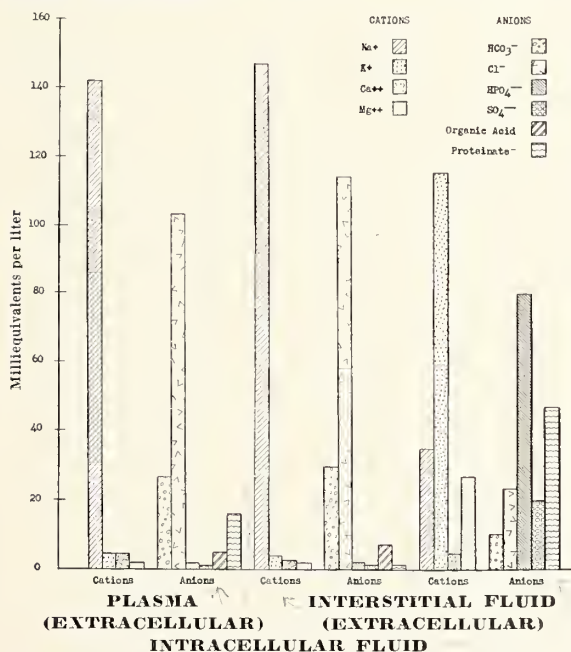
The body fluids contain chemical substances, chief among which are the "electrolytes." Electrolytes are substances which become ionized, that is, develop an electrical charge in water.

Certain substances develop a positive charge and are known as "cations." Others develop a negative charge and are designated as "anions." Taking as an example the familiar sodium chloride, in the body fluids sodium is ionized and develops a positive charge and is, therefore, a cation. Chloride develops a negative charge and is, therefore, an anion. The sodium ion, which is positive, can react with the basic hydroxyl ion, which is negative. The chloride ion, which is negative, can react with the acidic hydrogen ion,

which is positive. The sum of the cations must equal the sum of the anions in the body fluid in order that electrical equality be maintained.

The plasma contains the cations sodium, potassium, calcium and magnesium, and the anions chloride, bicarbonate, proteinate, phosphate, sulfate and organic acids. The interstitial fluid contains as its cations sodium, potassium, calcium and magnesium, and as its anions chloride, bicarbonate ( $\text{HCO}_3^-$ ), phosphate, sulfate, organic acids and proteinate. Within the cells are the cations potassium, sodium, magnesium and calcium, and the anions phosphate, proteinate, chloride, sulfate and bicarbonate. Refer to Chart II.

CHART II. Electrolytes of Intracellular Fluid and Extracellular Fluid.



Adapted from: Weisberg, H. F.: Water, Electrolyte and Acid-Base Balance: Normal and Pathologic Physiology as a Basis for Therapy, Baltimore, The Williams and Wilkins Company, 1953.

The unit of measurement of electrolytes is the milliequivalent, which expresses the *chemical-combining power* of an electrolyte. The older method of expressing electrolytes in terms of *weight* is outmoded. One would not compare the engine of an airplane to that of a locomotive on the basis of gross weight. For example, a locomotive that weighs 230,000 pounds has only 1,500 horsepower, while a certain airplane weighing about 45,000 pounds has 4,800 horsepower. Similarly, protein in terms of milligrams per 100 ml. weighs 6,500 mg., while it has a chemical-combining power of only 16 mEq. per liter. Sodium, with a weight of 326 mg. per 100 ml., has a chemical-combining power of 142 mEq. per liter. So protein is a locomotive, after a manner of speaking, and sodium an airplane!

The total plasma cations weigh only 358 mg. per 100 ml., but have the same chemical-combining power as the total plasma anions which weigh 6,948 mg. per 100 ml. Refer to Figures 2 and 3, and to Table 3.

The milliequivalent represents the "horse-power rating" of a given electrolyte. It is de-



TABLE 3.—Weight vs. Power

Internal Combustion Engines	Weight as Pounds	Power as Horsepower
Locomotive (C. & E. I.)		
Road Diesel) -----	230,000	1,500
Airplane (Martin 404) ----	44,900 (maximum)	4,800

Electrolytes	Weight in Milligrams Per 100 Milliliters	Chemical Combining Power as Milli- equivalents Per Liter
Protein (as Proteinate—) -----	6,500	16
Sodium (Na+) -----	326	142
Total Plasma Cations -----	358.4	154
Total Plasma Anions -----	6,948.7	154

fined as that amount of an element or ion which will combine with, or be equivalent in chemical-combining power to, 1/1000 of a gram atom of hydrogen. A different type of unit, the milliosmol, has been employed for the measurement of osmotic pressure. As far as problems in clinical fluid balance are concerned, the milliosmol can be disregarded and the milliequivalent used as a rough, though adequate, indicator of osmotic pressure, as well as of chemical-combining power.

DESCRIPTIVE SYSTEM OF  
DIAGNOSIS

Considerable confusion in the field of fluid balance has been caused by failure to employ an elastic descriptive system of diagnosis. Such a system, similar in principle to that employed for the descriptive diagnosis of heart disease, has been introduced by Moyer. With a few modifications, that system will be employed here. The first four of the six major types of imbalance described are as suggested by Moyer.

Our chief concern in assessing the various types of body fluid imbalance must be with the extracellular fluid, including the extracellular intravascular fluid or plasma, and the extracellular extravascular fluid or interstitial fluid. A simplified classification incorporates six major types of imbalance:

- The first includes *imbalances in the extracellular fluid volume*, which may consist either of a *deficit* or an *excess*.
- The second involves *imbalances in total salt concentration of the extracellular fluid* and includes *deficit* or *excess*.
- The third major type involves *imbalances of specific salts* and includes *deficits* of the electrolytes *potassium, calcium, protein, sodium,*

*chloride* or *bicarbonate*; or *excesses* of *potassium, calcium, protein, sodium, chloride, organic acids* or *bicarbonate*. Deficits and excesses of carbonic acid are included under this heading.

The fourth consists of *imbalance in the location of extracellular fluid*, which involves *distributional shifts* of fluid of the plasma to the interstitial fluid, or vice versa.

The fifth involves *imbalances in the supply of calories*. This includes first, *caloric deficit*. *Caloric excesses* have no application in clinical fluid balance problems.

The sixth includes *imbalances in the supply of vitamins*, and includes *vitamin deficits*. *Vitamin excesses* have limited application in fluid balance problems.

There is nothing complicated about caloric balance or vitamin nutrition, but the matters of *extracellular fluid volume, total salt concentration, composition* and *location of extracellular fluid* are not so simple. Since we can learn something about all of these variables from an examination of the plasma, let us use a very simple picture analogy in which we consider the plasma as contained in a beaker. Refer to Chart III. We will examine this mythical beaker with its content of plasma from the standpoint of variations in *volume, total salt concentration, composition* and *location*. For simplicity we have shown only four electrolytes which we can call "blue," "red," "yellow" and "green."

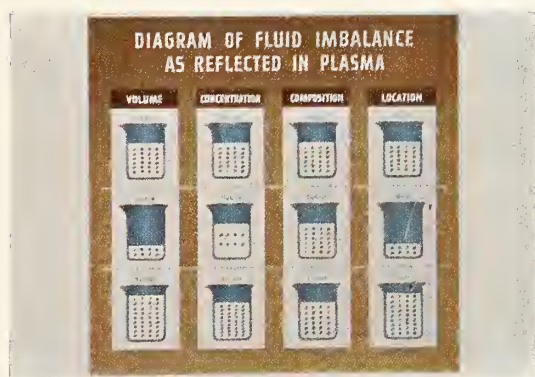
First let us consider *volume*. The top beaker in the first column on the left contains a normal volume of plasma. We can have a deficit or an excess in volume without change in concentration, composition or location, as portrayed in the middle and lower beakers.

Now let us look at *concentration*. We can have a normal concentration of electrolytes as shown by the top beaker in the second column, a deficit, as shown by the middle beaker, or an excess, as shown by the lower beaker, without variations in volume, composition or location.

In the third column we have pictured normal *composition* with equal amounts of the electrolytes "blue," "red," "yellow" and "green." In the middle beaker we have a deficit of "blue" and in the bottom beaker an excess of "blue." We can have a deficit or an excess of any one



Chart III. Diagram of Fluid Imbalance as Reflected in Plasma.



The "beaker analogy" shows variations in extracellular fluid as reflected in the plasma.

of the several electrolytes of the plasma, or we can have an excess of one or more and a deficit of one or more.

The fourth column refers to imbalances in the *location* of the extracellular fluid. Normally a certain proportion of the extracellular fluid is plasma and a certain proportion is interstitial fluid. The top figure shows the situation when the plasma has its normal share of the extracellular fluid. The middle beaker shows what occurs when, for one clinical reason or another, there is a shift of the fluid of the plasma into the interstitial space. The bottom beaker shows the situation when there is a shift of fluid from the interstitial space into the plasma.

Let us now consider each of the individual types of fluid imbalance, considering examples of *clinical conditions* leading to it, of *physical findings*, *symptoms* and *laboratory findings* diagnostic of it, and of the *principle of therapy* involved in its treatment.

## I. IMBALANCE IN EXTRACELLULAR FLUID VOLUME

### A. Extracellular Fluid Volume Deficit Without Significant Change in Electrolyte Concentration

An extracellular fluid volume deficit can be caused by a reduction of the fluid intake or by excessive loss of fluids as through vomiting, diarrhea or fistulous drainage. Typical symptoms include weakness and dizziness on standing.

A typical finding of an extracellular fluid

volume deficit is longitudinal wrinkling and shrinking of the tongue.

Typical laboratory findings include elevation of the hematocrit reading, the hemoglobin concentration and the red blood cell count. Chloride is practically absent from the urine, provided kidney function is good. When chloride is present in the urine in amounts greater than 5 Gm. per liter, the extracellular fluid volume is very likely not decreased. However, in the presence of Addison's disease and with rapid infusion of normal saline, the extracellular fluid volume can be far below normal even though 5 Gm. of sodium chloride is present in a liter of urine.

The aim of therapy in extracellular fluid volume deficit is to provide the patient with a parenteral solution having an electrolyte composition approximately similar to that of normal extracellular fluid, such as Lactated Ringer's Solution U.S.P., or Levugen 5% with Electrolyte No. 158.

### B. Extracellular Fluid Volume Excess Without Significant Change in Electrolyte Concentration

Extracellular fluid volume excess may be caused by parenteral administration of excessive amounts of sodium chloride.

Typical symptoms include hoarseness, shortness of breath and rapid weight gains. Physical signs may include distension of the peripheral veins and moist sounds in the lungs.

Typical laboratory findings include a hematocrit, red cell count and hemoglobin concentration below normal.

The rationale of therapy of extracellular fluid volume excess must be based on diminishing the excess fluid volume without reducing the electrolyte concentration of the extracellular fluid. It may be necessary to withhold all fluids for a period.

## II. IMBALANCE IN TOTAL SALT CONCENTRATION OF EXTRACELLULAR FLUID

### A. Deficit in Total Salt Concentration of Extracellular Fluid

A total salt concentration deficit may be caused by excessive sweating when replacement is accomplished only with water, excessive drinking of water, or both. Typical symptoms include headache, nausea, vomiting and muscular cramps.

Typical physical findings in a salt concentration deficit include convulsions with stuporous intervals, and absence of reflexes. Convulsions do not, however, occur in the aged or in very debilitated patients. Laboratory findings may include a low plasma sodium, a low concentration of chlorides in the plasma, and low urinary specific gravity. The sum of the plasma chloride and bicarbonate ions is usually less than 120 mEq./L.

The rationale of therapy in a salt concentration deficit is to provide electrolytes in order to retain normal salt concentration of the extracellular fluid without causing a fluid volume excess. Hypertonic solutions of saline are usually employed for this purpose, such as 3% or 5% Sodium Chloride Solution.

#### B. *Excess of Total Salt Concentration of Extracellular Fluid*

A salt concentration excess may be caused by a decreased intake of fluid or by excessive administration of electrolytes.

Typical clinical findings include thirst, restlessness and weakness, with a deficiency of saliva and tears.

Typical laboratory findings include an elevated specific gravity of the urine with an increase of the red blood cell count, hemoglobin value, hematocrit and plasma protein concentration. The plasma sodium will be found to be above 140 mEq./L. The sum of the plasma chloride and the bicarbonate ions will usually be above 130 mEq./L. in the absence of anoxia, renal insufficiency or metabolic acidosis.

The principle of therapy includes the dilution of the increased salt concentration. Thus, one administers a solution with a low electrolyte content or containing no electrolytes at all, such as a simple carbo-

hydrate in water solution; for example, Levugen 10% in water.

### III. IMBALANCE OF SPECIFIC SALTS (COMPOSITIONAL IMBALANCE) OF EXTRACELLULAR FLUID

#### A. *Potassium Deficit*

A potassium deficit may appear in such clinical situations as chronic pyloric obstruction, ulcerative colitis, healing phase of burns, fistulas of small intestine and colon, diarrhea, especially in infants, and in prolonged parenteral alimentation with potassium-free solutions, in postoperative stress reaction following cortisone administration and in diabetic acidosis.

Typical clinical findings include weakness and anorexia. Silent ileus is often found and there is a failure to achieve an appreciable gain in strength when solutions of sodium salts are administered. Typical electrocardiographic signs are present. An alkalosis resistant to sodium chloride, or an acidosis refractory to administration of a solution containing sodium lactate or sodium bicarbonate may occur in a potassium deficit.

Although a decreased plasma potassium is typical of potassium deficit, the plasma potassium *may be* normal or even increased early in a potassium deficit, since the *plasma potassium level* does not accurately reflect the *intracellular potassium stores*. Potassium should never be given parenterally unless renal function is relatively normal.

Therapy aims at supplying needed potassium to bring the plasma potassium back to its normal level. A useful solution is Potassium Chloride Solution 15% diluted in a liter of a carbohydrate in water solution.

#### B. *Potassium Excess*

Excessive amounts of potassium in the plasma may result from severe tissue damage, such as is caused by burns or scalds, by crushing injuries or by severe kidney disease.

Typical clinical findings include nausea, intestinal colic and diarrhea. The electrocardiograph shows a characteristic picture. In potassium excess, the serum potassium may be normal or decreased instead of increased, since the plasma potassium level does not always reflect the intracellular potassium stores.

If the excess of plasma potassium is uncomplicated, and the kidneys are functioning, treatment consisting of the avoidance of additional potassium, either by mouth or parenterally, suffices. One may administer, in addition, a simple carbohydrate in water solution; for example, Levugen 10% in Saline or Levugen 10% in Water.

### C. Calcium Deficit

A calcium deficit may result from loss of calcium from the body through fistulas of the small intestine or of the pancreatic duct system, from generalized peritonitis, from interference with the metabolic control of calcium due to surgical removal of parathyroid tissue, or from steatorrhea.

Typical clinical findings include numbness and tingling of the nose, ears and tips of fingers and toes, and tetany. An increase in neuromuscular activity and in the deep tendon reflexes may be observed.

Laboratory findings may include a normal or decreased plasma calcium. Of special importance is the ionized calcium. Weisberg suggests the following formula for determining the ionized calcium:

$$\text{Ca}^{++} = \frac{\frac{P}{P + 6} \text{ Ca} - \frac{3}{3} P}{\text{Ca in mg. per 100 ml.}} \quad P = \text{total protein gm./100 ml.}$$

Phosphorus will be elevated if hypoparathyroidism is present.

The purpose of therapy is to administer calcium parenterally; for example, by means of Calcium Gluconate Injection U.S.P. 10%.

### ACKNOWLEDGMENT

*It is a pleasure to acknowledge the help of Harry F. Weisberg, M.D., Assistant Professor of Clinical Pathology and of Clinical Medicine at the Chicago Medical School, and Clinical Chemist, Mt. Sinai Medical Research Foundation and Hospital, Chicago, Illinois, and of Charles G. Zubrod, M.D., Department of Internal Medicine, St. Louis University School of Medicine, St. Louis, Missouri, both of whom critically read a preliminary version of this manuscript and made numerous helpful suggestions.*

### D. Calcium Excess

Calcium excess is usually caused by hyperparathyroidism or excessive vitamin D administration.

Outstanding clinical features of calcium excess include deep bony pain and hypotonicity of the voluntary muscles. Widespread cavitation of the bones may be revealed by x-ray.

On chemical examination, the plasma calcium, especially ionized calcium, is found to be elevated above the normal level. Urinary output of calcium is greatly increased, sometimes shown by the excretion of fine calcium salts ("urinary sand"). The density of the precipitate produced in urine by the addition of Sulkowitch's reagent reflects the calcium level of plasma. Since the basic cause of calcium excess is a hormonal imbalance, parenteral therapy is not indicated. If other specific salt imbalances occur in conjunction with calcium excess, any treatment should exclude calcium ions.

### E. Protein Deficit

Protein deficit may result from such clinical situations as severe hemorrhage, starvation, extensive burns, trauma, repeated



surgical procedures, decubitus ulcers and infection.

Clinical findings include loss of weight with nutritional edema in severe degrees of the deficiency. Reduced resistance to infection, poor wound healing, anorexia and vomiting often occur.

Laboratory findings may include a reduction of the total plasma protein level or of the plasma albumin level. The hemoglobin level of the blood is usually below normal. The principle of therapy is to supply protein in a readily available form. This can be done through the provision of a diet rich in protein with adequate calories or through the parenteral administration of a protein hydrolysate solution, or both. A suggested solution is Amigen 5%, Levugen 10%.

#### F. Protein Excess

Protein excess may appear in such clinical situations as dehydration due to diarrhea, vomiting or extensive burns.

Laboratory findings consist of an elevation of the plasma proteins, elevated hemoglobin, elevated red blood cell count and elevated hematocrit.

The principle of therapy is to reduce the plasma protein level by dilution with a simple electrolyte solution, either isotonic or hypotonic in relation to plasma. A typical solution is Ringer's Solution U.S.P. A carbohydrate solution (for example, Levugen 10% in Water) may be used if there has not been any loss of electrolytes.

#### G. Deficits and Excesses of Sodium, Chloride, Organic Acids, Bicarbonate and Carbonic Acid

Deficits and excesses of these substances result in disturbances of the *acid base balance* of the plasma, and hence will be discussed together.

The degree of acidity or of alkalinity of a fluid is measured by the concentration of hydrogen ions. The greater the concentration, the higher the acidity. Conversely, the lower the concentration, the lower the

acidity. Since the actual weight of hydrogen ions in a liter of plasma is extremely small, it is more convenient to report hydrogen ion concentration in terms of "pH" which is the negative logarithm of the hydrogen ion concentration. Since the logarithm is a negative one, acidity increases as the pH value decreases and alkalinity increases as the pH value increases.

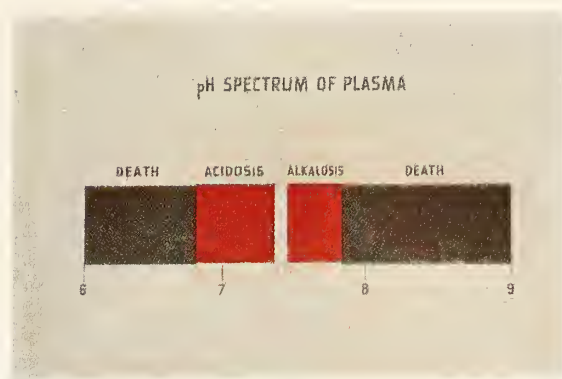
It is *not* necessary to understand the mathematical intricacies of the pH method of measuring acidity and alkalinity. It is important to keep in mind the normal values which indicate neutrality of the plasma, as well as the fact that *acidity increases with decreasing pH and decreases with increasing pH. Alkalinity increases with increasing pH and decreases with decreasing pH.*

The extracellular fluid of the body is normally maintained within the pH range of 7.35 to 7.45. As long as the pH of the extracellular fluid is between 7.35 and 7.45, the patient is in acid base balance. When the pH drops below 7.35, the patient is in a state of acidosis. When the pH of the extracellular fluid is above 7.45, then the patient is in alkalosis. Refer to Chart IV.

Normally, there are 1.35 milliequivalents of carbonic acid for every 27 milliequivalents of base bicarbonate (largely sodium bicarbonate) in the plasma. This is a ratio of approximately 1 to 20. When this ratio is disturbed, an abnormally acid condition of the plasma (acidosis), or an abnormally alkaline condition of the plasma (alkalosis) results.

As long as the ratio of 1 to 20 is maintained, regardless of the total amounts of carbonic acid or of base bicarbonate, neutrality is maintained. *This is the essential fact to remember if one is to understand acid base balance.* The carbon dioxide-combining capacity of the plasma is *not* reliable as a criterion of acid base balance. All this value indicates is the approximate amount of base bicarbonate. The carbon dioxide-combining power may be elevated

Chart IV. pH Spectrum of Plasma.

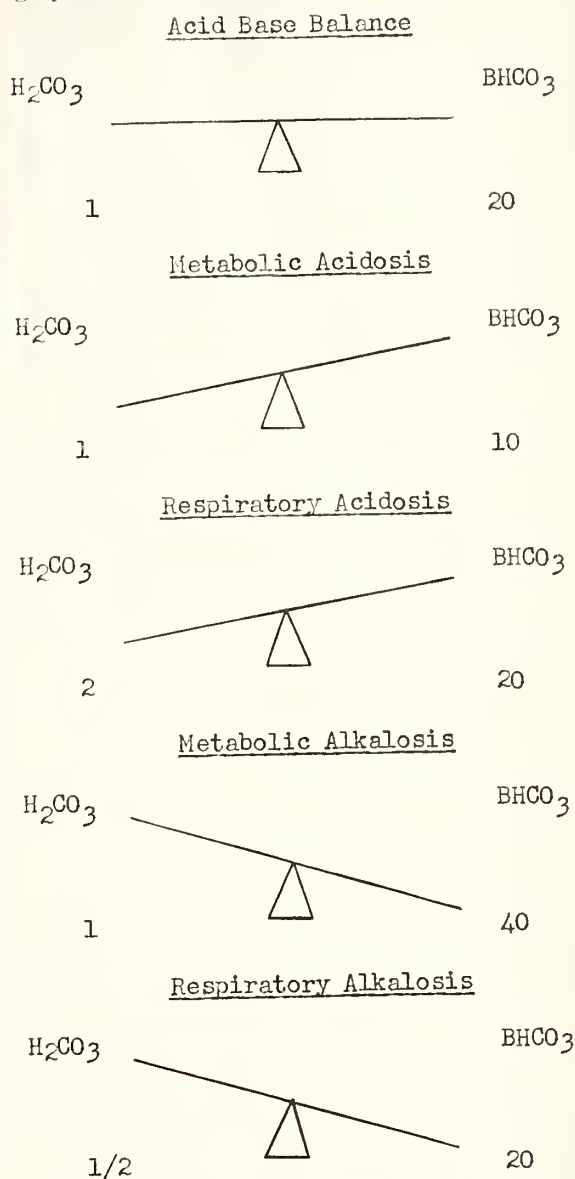


The "pH spectrum of plasma" shows the narrow limits of pH—pH 7.35 to pH 7.45—compatible with normality.

or decreased in either acidosis or alkalosis. Since the maintenance of normal acid base balance depends upon maintenance of the 1 to 20 ratio of carbonic acid to base bicarbonate, obviously any clinical condition which *increases* the *carbonic acid side* of the balance or *decreases* the *base bicarbonate side* of the balance will tend to result in acidosis. Any condition which *decreases* the *carbonic acid side* of the balance or *increases* the *base bicarbonate side* of the balance will tend to result in alkalosis. Acidosis or alkalosis may result either from metabolic or from respiratory disturbances. See Chart V.

In any disturbance of acid base balance, certain compensatory mechanisms normally come into play. The most important of these mechanisms are carried out by the lungs and kidneys. If the mechanisms are successful in maintaining the pH of the extracellular fluid within the limits of 7.35 to 7.45, acid base imbalance does not occur. If these mechanisms are acting successfully to combat clinical conditions which tend to cause acidosis, then the patient's condition is spoken of as a "compensated acidosis." If, on the other hand, mechanisms are acting successfully to counteract clinical conditions which tend to produce alkalosis, then the patient's condition is referred to as a "compensated alkalosis." When the mechanisms are not successful, then the patient is said to be in "acidosis" (that is, "uncompensated acido-

CHART V. Hypothetical Acid Base Balance Pictographs.



The chart shows hypothetical acid base balance "pictographs." Any clinical condition that "lightens" the base bicarbonate side of the balance or "weights" the carbonic acid side of the balance causes acidosis. Any clinical condition that "weights" the base bicarbonate side of the balance or "lightens" the carbonic acid side of the balance causes alkalosis. As long as the ratio between carbonic acid and base bicarbonate remains 1 to 20, or any multiple thereof, acid base balance is maintained.

sis") or in "alkalosis" (that is, "uncompensated alkalosis").

#### 1. Metabolic Acidosis

Metabolic acidosis may result from such a clinical situation as diabetes mel-

litus or severe infectious disease with liver impairment in which excesses of ketone bodies (betahydroxybutyric acid and acetoacetic acid) are produced. These abnormal acids are excreted in the urine with sodium, thus detracting from the base bicarbonate side of the carbonic acid:base bicarbonate balance. The result is a disturbance of the normal 1 to 20 ratio in favor of the carbonic acid side of the ratio. The pH of the plasma becomes more acid than normal.

Certain body compensatory mechanisms normally come into play. These include increased respiratory action to blow off carbon dioxide, which decreases the carbonic acid side of the carbonic acid:base bicarbonate ratio. The kidneys, too, attempt compensation by increasing acid excretion and decreasing excretion of base.

Although the pH of the urine is usually more acid than normal in acidosis, it may actually be alkaline when kidney infection occurs, in certain rare diseases such as Milkman's syndrome, or the Fanconi syndrome, or in children under 1 year of age. If the compensatory mechanisms are successful, then the normal ratio of carbonic acid 1 to base bicarbonate 20 is maintained. If these mechanisms are not successful, then the ratio is lowered. The carbon dioxide-combining power is decreased in metabolic acidosis.

Clinical symptoms of metabolic acidosis may include shortness of breath with mild exertion, deep periodic (Kussmaul) breathing and weakness progressing in severe cases to disorientation, stupor and even to coma in acidosis caused by diabetes.

Treatment is directed toward supplying water to repair the deficit and sodium to support the base bicarbonate side of the carbonic acid:base bicarbonate ratio. It should be recalled that in metabolic acidosis there has ordinarily

occurred a tremendous loss of water which must be replaced.

Carbohydrate, as dextrose, is not ordinarily given early in diabetic acidosis because it increases the concentration of the blood and causes further removal of water from the intracellular space. Use of insulin is, of course, of great importance in the management of diabetic acidosis. This holds whether dextrose or fructose is the carbohydrate employed in therapy. There are good reasons why fructose may be superior to dextrose for the management of diabetic acidosis.

(Seltzer, H. S., and Conn, J. W.: Fructose Metabolism in Diabetes: Clinical Application; J. Michigan M. Soc. 52:1095-1099; 1107, Oct., 1953.)

A suitable solution is Dextrose 5% in Lactated Ringer's Solution.

When acidosis proves resistant to sodium therapy, the possibility of potassium deficit should be considered. If the presence of a potassium deficit is established, a suitable solution of potassium should be given provided kidney function is adequate; for example, Potassium Chloride Solution 15% diluted in a liter of a carbohydrate in water solution.

## 2. *Moyer's Dilutional Acidosis*

This form of acidosis is really a type of metabolic acidosis caused by the excessive infusion of chloride, as "normal" or isotonic saline (0.9% solution of sodium chloride).

It is important to understand why it is incorrect to refer to this solution as "physiologic":

Normal Saline provides approximately 154 milliequivalents of sodium per liter, not a great deal more than does human extracellular fluid. The sodium content of Normal Saline is, therefore, in a sense physiologic. This solution also provides 154 milliequivalents of chloride. But extracellular fluid contains



only 103 milliequivalents of chloride. Thus, from the standpoint of extracellular fluid, Normal Saline provides an excess of 51 (154 minus 103) milliequivalents of chloride for each liter given. Normal Saline is, therefore, "unphysiologic" in its excessive contribution of chloride.

The effect of giving a patient a liter of Normal Saline is to give an excess of chloride. Since chloride tends to produce acidosis due to its affinity for  $H^+$  ions, Normal Saline (or any solution of sodium chloride) must be regarded as an acidosis-favoring solution. It is, therefore, useful in treating alkalosis but not acidosis, except in unusual circumstances.

When large amounts of saline are unwisely given, the excess of chloride in the plasma removes sodium from the base bicarbonate side of the carbonic acid: base bicarbonate ratio. This relative excess of chloride tends to produce acidosis. The tendency is increased should sodium leave the extracellular fluid and enter the cells, thus accentuating the chloride excess.

The body attempts compensation by the blowing off of excess carbon dioxide and by increased acid excretion and sodium bicarbonate retention by the kidneys. The pH of the urine becomes acid. If compensation is successful, the carbonic acid:base bicarbonate ratio of 1 to 20 is maintained. If not, the ratio is altered in favor of carbonic acid.

Clinical findings in Moyer's dilutional acidosis are similar to those observed in metabolic acidosis.

Therapy is directed toward supplying sodium in some form such as sodium lactate, to support the sodium bicarbonate side of the carbonic acid:base bicarbonate ratio.

This form of acidosis can be avoided by replenishing extracellular fluid volume deficits with such solutions as

Dextrose 5% in Lactated Ringer's Solution.

### 3. *Respiratory Acidosis*

Respiratory acidosis is caused by such clinical situations as retarded respiration caused by pneumonia, emphysema or morphine poisoning. There is a primary retention of carbon dioxide with a resultant increase of carbon dioxide and, hence, of carbonic acid in the blood.

The carbonic acid side of the carbonic acid:base bicarbonate ratio is favored, and the carbonic acid:base bicarbonate ratio becomes less than 1 to 20, with the pH of the blood more acid than normal. The carbon dioxide-combining power is normal or increased as the base bicarbonate rises in attempted compensation.

The body also attempts compensation by a shift of acid, chiefly chloride, into the intracellular fluid. Kidney compensatory action consists of increased acid excretion. The urine pH becomes acid. If the body compensatory mechanisms succeed in maintaining the carbonic acid:base bicarbonate ratio of 1 to 20, then the acidosis is said to be compensated. Otherwise, it is said to be uncompensated, since the blood pH drops below the normal range.

Clinical findings in uncompensated respiratory acidosis may include respiratory embarrassment, weakness, disorientation and coma.

Of primary importance in the *treatment of respiratory acidosis*, is the relief of the clinical causes of the imbalance. Unless these are corrected, or at least partially corrected, parenteral therapy will be of little help. Parenteral therapy is directed at supplying sodium which supports the base bicarbonate side of the carbonic acid:base bicarbonate ratio. A suitable solution is Lactated Ringer's Solution U.S.P. M/6 Sodium Lactate Solution

should be used only if the acidosis is severe.

#### 4. *Metabolic Alkalosis*

Metabolic alkalosis may be caused by the ingestion of large amounts of sodium bicarbonate or by loss of chloride through vomiting or gastric suction. There is an increase in base ions and, therefore, an increase in the base bicarbonate. The carbonic acid:base bicarbonate ratio is disturbed in favor of the base bicarbonate and the pH of the blood becomes more alkaline than normal. The carbon dioxide-combining power is usually increased.

Compensation includes an increased excretion of sodium bicarbonate by the kidneys. Ordinarily the pH of the urine is alkaline in alkalosis; it may, however, be acid if dehydration has occurred, or if there has been a severe loss of gastric juice through vomiting or gastric suction. If compensation is successful, the carbonic acid:base bicarbonate ratio is maintained at 1 to 20.

If compensation is not successful, it is increased in favor of the base bicarbonate.

Clinical findings in uncompensated metabolic alkalosis may consist of tetany, if the condition is severe, or may be absent.

Therapy is directed at the supplying of chloride which removes the excess sodium or other base from the sodium bicarbonate side of the carbonic acid:base bicarbonate ratio. A suitable solution is Normal Saline, Ringer's Solution U.S.P. or, according to some authorities, ammonium chloride solution. In giving isotonic saline, one is giving more sodium, even though he is at the same time administering a relative excess of chloride. Thus, some believe that either ammonium chloride or Ringer's Solution U.S.P. is preferable to Normal Saline for the correction of metabolic alkalosis.

The possibility of potassium deficit should, of course, be considered in every case of metabolic alkalosis. When metabolic alkalosis is due to potassium deficiency, it can frequently be corrected by the administration of potassium by mouth.

#### 5. *Respiratory Alkalosis*

This condition is caused by an increased rate and depth of breathing, such as results from oxygen lack in high altitudes, from encephalitis or in the early stages of salicylate intoxication. This is especially important in infants and children. There is an increased excretion of carbon dioxide through the lungs with a resultant decrease in the carbon dioxide tension of the blood and a decrease in the carbonic acid side of the carbonic acid:base bicarbonate ratio. As a result, the carbonic acid:base bicarbonate ratio of 1 to 20 increases and the pH becomes more alkaline than normal.

Compensation is attempted by the kidneys, which increase the retention of acid and increase the excretion of sodium bicarbonate. Urine pH becomes alkaline.

If compensation is successful, the carbonic acid:base bicarbonate ratio of 1 to 20 is maintained and the blood pH remains within the normal limits. If not, the ratio is disturbed and the blood becomes more alkaline than normal. The carbon dioxide-combining power is ordinarily decreased as the base bicarbonate side of the carbonic acid:base bicarbonate ratio follows the carbonic acid side of the ratio downward.

Clinical findings in uncompensated respiratory alkalosis may be absent. If the alkalosis is severe, alkalotic tetany could occur.

Of primary importance in the *treatment of respiratory alkalosis*, is the relief of the clinical causes of the im-

balance. Unless these are corrected, or at least partially corrected, parenteral therapy will be of little help.

Parenteral therapy is directed at supplying chloride in order to remove sodium from the base bicarbonate side of the carbonic acid:base bicarbonate ratio. A suitable solution is Ringer's Solution U.S.P.

#### IV. IMBALANCE IN LOCATION OF EXTRACELLULAR FLUID

This imbalance consists of a distributional shift of fluid from the plasma to the interstitial fluid space. It may be caused by such clinical situations as burns, scalds, fractures or crushing injuries. Likewise, there are inflammatory, chemical and vascular causes of distributional shifts.

The clinical findings include swelling of an injured part, severe weakness and low blood pressure.

The hematocrit reading, hemoglobin concentration and the red cell count will be found to be above normal.

In parenteral therapy, the aim is to replace the electrolytes and large molecules of plasma with such solutions as blood, Plasran 6% (Dextran, Mead), and electrolyte repair solutions such as Levugen 5% with Electrolyte No. 158.

A second distributional imbalance consists of fluid shifts from the interstitial space to the plasma, caused by external or internal hemorrhage or trauma.

Typical clinical findings reflect the dilution of plasma and consist of low blood pressure, weakness and shock.

Typical laboratory findings include decreased hematocrit, decreased hemoglobin and decreased red cell count.

Ordinarily, therapy is not indicated. However, if the shift of fluid from the interstitial space to the plasma, which may occur early in hemorrhage, is also accompanied by pronounced blood loss, blood transfusion would be indicated.

#### V. IMBALANCE IN SUPPLY OF CALORIES

##### A. *Caloric Deficit*

A caloric deficit can result from any clinical situation where there is decreased intake of food.

Clinical findings include weakness and loss of weight.

The principle of therapy involved is the supplying of calories in the form of fructose, dextrose or alcohol.

##### B. *Caloric Excess*

Caloric excess is not of importance from the standpoint of fluid balance.

#### VI. IMBALANCE IN SUPPLY OF VITAMINS

##### A. *Vitamin Deficit*

A vitamin deficiency may result from any condition which causes decreased intake of food, such as prolonged illness.

Typical clinical findings which may result from vitamin deficiency include impaired wound healing, as in vitamin C deficiency, or impaired utilization of carbohydrates, as in deficiency of members of the vitamin B complex.

Parenteral therapy includes the administration of needed vitamins in parenteral solutions.

##### B. *Vitamin Excess*

Vitamin excess is not of importance in conjunction with body fluid balance. One exception is an excess of vitamin D which causes hypercalcemia.

Six basic types of imbalance have been described, with subvarieties under each type. *It should be recalled that any given instance of fluid imbalance may involve only one of the basic disturbances listed, or it may involve a combination of individual imbalances of varying degrees of severity.* Careful assessment of the patient from all six standpoints is essential if one is to achieve success with parenteral fluid therapy.



Analysis of clinical conditions resulting in fluid imbalance (e.g., infantile diarrhea, severe vomiting, intestinal fistula, etc.) from the standpoint of variations in volume, concentration, composition and distribution is most helpful in arriving at a basic understanding of these conditions.

PARENTERAL SOLUTIONS

Although the number of parenteral solutions is great, it should be recalled that the purpose of any of these solutions is to supply one or more of the following:

- (1) Water for correction of extracellular fluid volume deficit, always given with carbohydrate in the form of fructose or dextrose. Typical solution: Dextrose 5% in Water.
- (2) Carbohydrate (fructose, dextrose or alcohol) for correction of caloric deficits or to promote utilization of ketones. Typical solution: Levugen 10% in Water.
- (3) Balanced amounts of salts for replacement of multiple electrolyte deficits. Typical solution: Lactated Ringer's Solution U.S.P. See Table 2.
- (4) High concentrations of individual salts which may be in deficit. Typical solution: Potassium Chloride Solution 15%. See Table 2.
- (5) Protein hydrolysates for correction of protein deficit. Typical solution: Amigen 5%, Dextrose 5%. See Table 2.
- (6) Large molecules for the restoration of plasma volume. Typical solution: Plasran 6% (Dextran, Mead).
- (7) Vitamins for correction of vitamin deficits.

If a given solution is analyzed from the standpoint of the contributions it makes in these regards, its purpose often becomes apparent.

The number of solutions available for parenteral fluid therapy is far greater than is actually required for adequate therapy. Actually not more than from six to eight basic solutions are required for the treatment of all body fluid imbalances.

REMARKS CONCERNING THERAPY

It is said that in years gone by, obstetricians would find a motto on the wall of the delivery room which read, "Primum Nihil Nocere!"—"First do no harm!" Certainly this warning should be borne in mind in the management of fluid balance problems.

After a tentative diagnosis has been reached, the physician should administer the appropriate solution or solutions required to correct the fluid imbalance or imbalances. An accurate knowledge of the patient's intake and output of water and electrolytes is essential for proper diagnosis and therapy. Such knowledge is not easily obtained,

TABLE 2.—Electrolyte Content of Various Parenteral Solutions in mEq./1000 ml.

SOLUTION	CATIONS (+)					ANIONS (-)		
	Na	K	Ca	Mg	NH <sub>4</sub>	Lac- Cl	tate	HPO <sub>4</sub>
All Amigen 5% Solutions	30	15	--	--	--	22	--	23
Amigen 3 1/3%, Dextrose 3 1/3% in 1/3 L.R.S.	65	10	5	1	--	48	9	16
Levugen or Dextrose in Saline Solutions	154	--	--	--	--	154	--	--
Levugen 10% with Electrolyte No. 45	30	15	--	--	--	35	--	10
Levugen 5% with Electrolyte No. 75	40	35	--	--	--	40	20	15
Levugen 10% with Electrolyte No. 150	63	17	--	--	70	150	--	--
Levugen 5% with Electrolyte No. 158	140	10	5	3	--	103	55*	--
Dextrose 5% in Ringer's Solution	147	4	4	--	--	155	--	--
Dextrose 5% or 10% in Lactated Ringer's Solution	130	4	3	--	--	109	28	--
Normal Saline 3% Sodium Chloride Solution	154	--	--	--	--	154	--	--
M/6 Sodium Lactate Solution	513	--	--	--	--	513	--	--
Ringer's Solution U.S.P.	167	--	--	--	--	--	167	--
Lactated Ringer's Solution U.S.P.	147	4	4	--	--	155	--	--
Darrow's Solution	130	4	3	--	--	109	28	--
Potassium Chloride Solution 15% diluted in 1000 cc.	122	35	--	--	--	104	53	--
Calcium Gluconate Injection U.S.P. 10%	--	30	--	--	--	30	--	--
0.1% Procaine Hydrochloride in Saline	--	--	4.5	--	--	--	--	--
	154	--	--	--	--	154	--	--

\* 47 acetate plus 8 citrate.

for it involves not only an understanding of normal and abnormal gains and losses of fluids, but also careful intake records and qualitative and quantitative measurement of fluids lost as vomitus, tubal drainage, wound seepage, perspiration, urine, stools, etc.

If the patient improves, therapy is continued until balance is restored, with care taken not to continue treatment too long. If the patient fails to improve or becomes worse, therapy should be discontinued immediately. A fresh look should be taken at the clinical situation, and a new diagnosis made.

Moyer suggests that abnormalities of salt concentration be corrected first. Following this, he advises that extracellular fluid volume deficits be repaired and consideration given to compositional imbalances. Solutions chosen for correction of salt concentration deficits should, if possible, be appropriate for the management of any extracellular fluid volume deficits and compositional deficits present.

It should be emphasized, as Weisberg has so well pointed out, that the "therapy of each patient is a separate problem." Every case may require a different therapeutic approach. A knowledge of the disturbances present gives the physician a rational basis for the approach. It follows that no simple compendium or "cook-book" can possibly be a useful guide to the physician in the management of patients with fluid imbalance.

While our discussion has been primarily concerned with *parenteral* therapy, oral therapy, either by mouth or through nasal tube, should not be forgotten. Protein, for example, can be given effectively by mouth or tube, as Sustagen. Oral electrolyte mixtures, such as Lytren, are valuable when the patient can take substances by mouth or tube. It is always safer to give electrolytes by the oral than by the parenteral route, provided no contraindication exists to oral administration. It is generally accepted that the oral route, for example, is the preferred method of giving potassium.

Although rational parenteral therapy is invaluable in the management of many fluid balance problems, correction of the clinical disturbances responsible for the imbalance is frequently as important as parenteral therapy and sometimes more important.

There is probably no field of medicine in which there has been less clinical application of known facts than is the case with the tremendously important subject of fluid balance. This may be due to the fact that the subject has been incorrectly regarded as incomprehensible by many physicians. It is our sincere hope that this presentation has helped, in part at least, to correct this prevalent misconception.

### SUGGESTED REFERENCES FOR READING ON FLUID BALANCE

As emphasized in the preface, this article is intended only to aid in the orientation of the physician in the field of fluid balance. Monographs and articles which the authors have found especially helpful are listed on the following pages.

Among the monographs, Moyer's *FLUID BALANCE* and Weisberg's *WATER, ELECTROLYTE AND ACID-BASE BALANCE* are truly outstanding in their clarity, readability and usefulness.

Among the articles, Merrill's "Body Fluids and Electrolyte Balance" is recommended as an article on the general subject of fluid balance. The others cover specific problems of importance.

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# The Changing Outlook on Cancer and Its Treatment

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**I**NSTRUCTION of physicians and the laity on cancer control has been long and unceasing. Millions of dollars have been spent on cancer research. Treatment is applied earlier and has become more and more radical. The time has come for an appraisal of the results of all this and for a frank statement on what has been learned about cancer and on what has been accomplished in curing it. We consider, to this end, four questions:

1. Have we lowered the death rate from cancer?
2. Have we given the laity correct information about it?
3. Are the concepts which have controlled its treatment valid?
4. What, in light of present knowledge, is its proper treatment?

## I. The Death Rate:

The vital statistics of Connecticut are accurate; the doctrine of early treatment has been constantly preached to its people for 30 years; cancer treatment there has probably been as early and good as anywhere; yet there, as the following table shows, the total death rate and the death rate from all but one form of cancer was much higher in 1948 than in 1937.

DEATH RATE IN CONNECTICUT PER 100,000  
POPULATION IN 1937 AND 1948\*

	1937		1948	
	Male	Female	Male	Female
Digestive Organs-----	74	62	94	72
Breast -----	--	30	--	37
Uterus -----	--	25	--	21
Lungs -----	12	5	29	6
Urinary Organs-----	11	5	13	8
TOTAL -----	97	127	136	144

\* After Macdonald (Ref. 4).

Note that the rate for men increased from 97 to 136 and for women from 127 to 144. Note also that the only decrease in the rate for cancer of any organ was a small one for cancer of the uterus.

In Massachusetts, where conditions are as favorable to cancer control as in Connecticut, the death rate for breast cancer was 18 per 100,000 in 1938, and 20 per 100,000 in 1948.<sup>2</sup> This is significant because operations for breast cancer tend to be "early."

The cancer death rate for the registration area of the United States was 113.4 in 1930 and 120.9 in 1945. For Indiana it was 125.57 in 1943 and 144.09 in 1952. All writers comment on the alarming increase of the frequency of death from cancer of the lung.

No respectable authority, to my knowledge, now seriously claims that the all-out war on cancer has decreased the number of cancer deaths. The number, in fact, is increasing in spite of early and radical treatment.

## II. The Dictum That Early Cancer Is Curable Cancer:

This summarizes what the people have been taught about cancer control. It provides a trite explanation of the poor results of treatment and to most writers gives the only hope they seem to have of improving these results.

The people and their physicians are now as thoroughly terrified about cancer as they can be, and this has resulted in operation as early as can with reason be expected. It is extremely doubtful that by periodic screening of the population for cancer,<sup>6</sup> even were this possible, we could discover a sufficient number of early growths to change the overall results of treatment.

The disappointing results of so-called early operation<sup>2, 3, 4</sup> cannot be explained away. They

are, in fact, worse for cancer of the breast, stomach and colon, and for sarcoma of bone, than the results of later operations. This is probably true for lung cancers, also. Early treatment, of course, gives better results than late treatment for growths like rodent ulcer which increase by local extension only and for some slow-growing squamous cell cancers, but the information we now have shows that the course of the major forms of cancer depends far more on their inborn characteristics and on how much ability their hosts have to oppose them, than on how early they are treated. The more malignant growths cause alarming symptoms sooner, are therefore treated sooner, and, despite this, kill sooner than the less malignant growths. The first symptoms they cause are often due to their distant metastases. This is true, according to Macdonald and Kotin,<sup>3</sup> of 40% of all cases of gastric cancer. They state that a patient in this group "never has a chance to temporize, for as far as the primary site of the lesion is concerned, the traditional signals of danger never become manifest. The 'earliest' symptoms thus bespeak incurability."

It is often impossible, at autopsy on patients dead of carcinomatosis, to find the site of the primary growth.

Writers, with few exceptions, confuse the two meanings of early in this connection.<sup>2</sup> It may mean of short duration or of limited extent. A growth of short duration may have a great extent, and vice versa. In propaganda to the laity and in scientific writings, the duration of a growth is usually assumed to be the time between its discovery and its treatment. This is wrong. Its real duration is the time between its start in one or more cells and its discovery or treatment. This duration for some growths is only a few weeks long. These may establish widespread metastases before they can be discovered by any means of diagnosis we now possess. Other growths may remain in this pre-clinical period for years. We know from autopsy reports that 25 percent of all men over 50 years of age have minute cancers of their prostates. Nearly all of these growths either remain dormant as long as their hosts live, or disappear spontaneously, otherwise cancer of the prostate would be a much more common cause of death than it is. It is possible that conditions like these in the prostate exist in other organs.

Dr. C. G. Culbertson,<sup>2</sup> with a special technique, has found cancers of microscopic size in breasts removed for benign lesions. Perhaps the innate resistance of the body to lawless growth of its cells destroys most of these little cancers. Perhaps the spontaneous cure of cancer is not as rare as we think it to be. Metastases may remain quiescent for decades, and then suddenly start growing. Latent metastases of breast cancer have been discovered at autopsy 40 years after operation. Cancer may be a very chronic disease.

Further elaboration of this topic is unnecessary. The foregoing facts prove that the dogma of early treatment must be radically changed. Early treatment is perhaps better than later treatment, but not so much better as it has been assumed to be. Its results for the major forms of cancer are statistically worse than those of later treatment. The frantic effort to discover incipient cancer is not without danger and should be checked. It has not lowered the cancer death rate; it causes needless operations and its results are sometimes tragic; for example, the finding, after pancreatectomy or radical prostatectomy, of no cancer in the specimen.

Misinformation of the people on cancer will not promote its control. To hold their confidence, we must tell them the truth about it. The truth cannot possibly make them fear it more than they fear it now. The truth is not as terrifying as the indirect suggestion of doom carried by the present propaganda. The people can well be told: (1) That death from cancer is no more dreadful than death from many other diseases, and that they all must die of something; (2) That cancer is often a chronic disease which may last for years without causing its victim pain or disability; (3) That our treatment is good enough to cure some patients, to prolong in comfort the lives of many others, and to prevent suffering in all.

### III. Are the Concepts Which Have Controlled Cancer Treatment Valid?

There has been but one fundamental concept on cancer treatment. Handley, over 50 years ago, announced this as a discovery he had made by autopsy studies on women dead of breast cancer. He stated that breast cancer spreads, with few exceptions, as an unbroken growth

within and along lymph vessels, so that no matter how extensive it becomes it remains a continuous whole. From this, it follows that its complete removal is possible, provided you can cut far enough around it. This is the principle of block dissection. A second deduction from Handley's dictum on cancer spread was that the sooner operation is done, the better the chance of removing the growth. Hence the all-important value attached to early operation.

These ideas form a precise and plausible doctrine, well suited for propaganda to physicians and the laity. They were first applied to treatment of breast cancer; soon, to treatment of cancer anywhere. Many surgeons, unconsciously I think, have modified the idea of how cancer spreads to justify their operations for cancers impossible to remove by a true block dissection. They believe that cancer spreads, not by continuous growth within lymph vessels, but by sending out emboli of cells along these vessels to lymph nodes. This idea is implicit in the reports on the many toilsome searches for all the lymph nodes which may arrest cells from cancers of various organs. It is a consequence of the observation that cancer in lymph nodes indicates a bad prognosis. It has been a chief cause of the extremely radical operations being done by many surgeons. They apparently believe that the total removal of a cancer can be accomplished by removal of the primary growth and of all lymph nodes reached by its cells. The acceptance of this belief by so many writers on cancer is astonishing. There is no doubt that emboli of cancer cells can reach lymph nodes, but there is also no doubt that the lymph vessels around the cancerous nodes and between them and the primary growth also contain cancer. Cancer can never be cured by picking out cancerous nodes, no matter how many times you go back to look for them.

Advocates of the very radical operations in question ignore or minimize the importance of the evidence showing that the transport of cancer cells by the blood is a common occurrence and increases in frequency with the extension of the growth along lymphatics. Willis,<sup>8</sup> in his monograph on "The Spread of Tumors in the Human Body," states: "Venous invasion is not peculiar to any particular class of neoplasms, but is exhibited in greater or less degree by almost all types of malignant growth." This monograph is a report on the most thorough study of cancer

spread ever made and should be studied by every surgeon who treats cancer. He cannot help deriving from it a wise conception of the limitations of its surgical treatment.

The foregoing considerations make it highly improbable that advanced metastasizing cancer can be extirpated by any operation,<sup>4, 5</sup> no matter how radical it may be. This conclusion is supported also by the disappointing—often deplorable—results of too radical operations.<sup>5, 7</sup> Amputation of all the body below the level of the umbilicus for the cure of advanced cancer situated in the pelvis—and this seems to have been proposed—would, in light of present knowledge, be very unlikely to accomplish its purpose. The all-or-none, kill-or-cure method of treating cancer has been tried long enough.

#### IV. What Is the Proper Treatment of Cancer?

Many papers on cancer treatment start with the statement that any worthwhile operation for it must be planned to accomplish its total removal. The following considerations make us doubt the truth of this assumption:

1. Cancer spreads by its local growth, by way of lymph vessels and by way of the blood stream, and each metastasis is a secondary center of spread.
2. Even though its spread were by lymph vessels only, its extirpation, once it had reached lymph nodes, would seem to be well nigh impossible. Doubts that this can be done troubled even Halsted.<sup>2</sup> He wrote, what is entirely true, that "The division of one lymphatic vessel and the liberation of one cell may be enough to start a new cancer."
3. We cannot discover the more malignant growths by any means we now have before they have established distant and irremovable metastases.
4. The accumulated evidence now forces us to believe that whatever good results we achieve by our operations for disseminated cancer are in most cases due to factors other than its total removal, and that the most important of these is the body's innate resistance to new growths. I have



elsewhere recorded the observation that this resistance may be destroyed by improper radiation.<sup>2</sup> It seems probable that it may be destroyed also by the combination of prolonged anesthesia, great injury to tissues and multiple blood transfusions, incident to very extensive operations.

5. Appraisal of the results of operation is difficult and likely to be fallacious. Though we may obtain a clinical cure lasting many years, we can never be certain that this is not associated with latent metastases which may become active at any time.

The foregoing facts do not prove that the operative treatment of cancer is useless, but they do prove that it should be governed by clinical judgment and knowledge of the natural course of cancer, not by pride in technique and theories which are plainly false.

Any operation for metastasizing cancer must offer a reasonable expectation of making the patient's condition more tolerable; it can offer only a hope of cure. The writer's opinion is that good results of operations for these cancers are due chiefly to body resistance to their growth; that they are seldom or never totally removed. We should keep in mind that most untreated internal cancers kill by their local growth. When the patient has been rid of this, he may live in

comfort with the metastases for a long time. We should not deprive him of this possible benefit by a hopeless attempt to remove all the metastases.

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# Surgical Treatment of Meniere's Disease\*

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**B**EFORE ENGAGING in surgical treatment of Meniere's disease, it is necessary to stress careful and accurate diagnosis. We must realize that Meniere's disease is not Meniere's syndrome, but a specific entity consisting of a hydrops of the labyrinth.

The predominating symptom, and the most distressing and disabling one, is vertigo. The most consistent symptom, usually the first to occur, and the one necessary for diagnosis, is the loss of hearing. Other symptoms and findings necessary to a positive diagnosis in a full-blown case are tinnitus, diplacusis, equal or over recruitment, and a lowered threshold of discomfort.

Many conditions will produce the symptom vertigo, such as:

1. Toxins from systemic virus and bacterial infections, middle ear disease, poisons and drugs.
2. Vascular diseases, including arteriosclerosis, vasospasm and thrombosis of the posterior inferior cerebellar artery or other parts of the vascular tree supplying the peripheral or medullary centers of the 8th nerve, the cerebellum and even the cerebral cortex.
3. Blood dyscrasias such as anemias and leukemia may affect this sensory organ, which is very susceptible to anoxia like the rest of the central nervous system.
4. Nervous system pathology; for instance, carotid sinus syndrome, tumors and multiple sclerosis.

Finally, surgical treatment for hydrops of the labyrinth should not be resorted to until all med-

ical measures have been tried and failed. If the surgery is to be destruction of the labyrinth, useful cochlear function should be present in the other ear and one or more of the following circumstances must prevail:

1. The patient is incapacitated.
2. The patient cannot be under more or less constant observation and treatment.
3. The loss of time from work creates an economic hardship.
4. The attacks of vertigo occur without warning and the patient falls, endangering his life.
5. The psychosomatic disturbance is severe.
6. The condition does not exist bilaterally—in which case alternate stellate ganglion blocks and finally streptomycin (not dihydrostreptomycin) may be tried.

There is always the question of whether, after destroying the labyrinth surgically on one side, the patient will develop the same condition on the opposite side. Wright in England reported that out of 100 of his cases there were 72 with unilateral involvement. Of these 72, 13 later developed Meniere's in the opposite ear. This is approximately 18%. The longest interval before onset was 25 years, the shortest, 8 months; and in 9 of the 13 cases the interval was greater than 10 years. Useful hearing was lost in only one case. His conclusions are that Meniere's does not frequently produce a high-grade deafness in both ears; when it does so, it is usually of bilateral onset. Day reported 220 cases, with 27 having bilateral involvement, or 12%. In all but 4 it occurred simultaneously in both ears. He has had only one case develop Meniere's in the unoperated ear following surgery. In this case

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there was only cochlear pathology, which was controlled by medical treatment.

This emphasizes the need for careful post-operative follow-up over a period of years that medical treatment may be instituted early before permanent irreversible damage occurs in the unoperated ear.

I shall divide the surgical approaches to Meniere's disease into the following groups:

#### Group 1—Destruction of the end organ.

- a. Injection of alcohol into the vestibule through the oval window (Wright) or into a fenestra in the external semicircular canal (Mollison). The objection to these procedures has been the rather high incidence of facial paralysis.
- b. Labyrinthectomy by avulsion of the membranous horizontal canal. This technique of Cawthorne's is perhaps the most world-wide popular method.
- c. Mechanical destruction and electrocoagulation as described by Day.
- d. Lempert's decompression operation by removing the stapes and destroying the round window membrane.

**Group 2—Decompression by the Portmann operation on the endolymphatic sac.** This procedure, clinically, is in more or less disrepute. The abolition experiments of Lindsay, Neff, Schuknecht and Perlman on the ductus endolymphaticus, the sac and the periotic duct in cats, did not cause hydrops or a change in hearing.

**Group 3—Anesthetic and toxic injury to the labyrinth, the chorda tympani, and tympanic plexus by the Ersner and Spiegel injection of 2% cocaine and/or 35-50% alcohol into the middle ear after plugging the Eustachian tube.** It would seem that if Mollison's method may cause facial paralysis, this should too besides possible sloughing of the middle ear mucosa and drum.

#### Group 4—Neurosurgical approaches.

- a. Rosen's section of the chorda tympani.
- b. Novocaine block of the stellate ganglion.
- c. Garnett Passe's division of the preganglionic sympathetic fibers of the 2nd and 3rd

thoracic roots and cutting the sympathetic trunk below the 3rd thoracic ganglion.

- d. Differential or complete section of the 8th nerve as originated by Dandy.

Green and Douglas reported in 1951 on a follow-up of Dandy's cases. In complete section of the nerve, 9% had a permanent facial paralysis; in incomplete section, 1.7%.

The cochlear portion is difficult to separate from the vestibular portion where the nerve leaves the internal auditory meatus. They more or less blend together. Stacy Guild reports on this in a review of Dandy's cases and entitles it "The Effects on Hearing of Partial Section of the Cochlear Nerve." He notes that in one-fourth of the cases of partial section the upper limit of hearing had dropped one octave due to cutting a portion of the cochlear nerve.

Vertigo is relieved almost the same by partial as complete section in 91%. The 9% failures must represent in a large part inaccurate diagnosis. However, on partial nerve section it is easy to miss part of the vestibular nerve.

In my opinion, the facial nerve injury that may occur, especially with total section and the relatively uncertain results as far as hearing is concerned in partial section (without relieving the obnoxious tinnitus and distorted hearing), make these procedures a poor choice. If it were not for the large percentage of facial paralyses, total section would be the procedure of choice between these two, because it should eliminate the severe tinnitus and distorted hearing. Medical treatment in early cases is much improved over Dandy's time; therefore, the cases coming to surgery now should be the extremely severe ones with usually unserviceable hearing.

Before describing the surgical techniques of the Lempert and the Cawthorne and Day procedures, which, I believe, are the surest and safest labyrinthectomies, I wish to present several modes of attack via the sympathetic nervous system. A stellate ganglion block with novocaine as done by Hoogland of Holland should be tried before doing a labyrinthectomy if there is any question about preserving hearing, or, of course, in bilateral involvement.

An attack on the autonomic nervous system in the treatment of Meniere's disease is predicated on the supposition that Meniere's disease starts as a vasoconstrictive phenomenon. This results



in an anoxia with subsequent over dilation and leaking of the weakened capillary bed. Therefore, if this vasoconstriction could be prevented, the disease would be stopped. Of course, prior irreparable damage would not be altered. Most modern medical treatment of the disease rests on the supposition of vasoconstrictive attacks as the precipitating factor.

The parasympathetic supply to the labyrinth<sup>8</sup> is supposedly by way of the geniculate ganglion. Parasympathetic stimulation should cause a vasodilation of the labyrinth. Conversely, sympathetic stimulation via fibers from the stellate ganglion causes vasoconstriction.

The stellate ganglion is composed of the fused inferior cervical and first thoracic ganglia. From it, fibers supply one-half of the head and neck.

Hoogland's treatment is by novocaine block of the above ganglion, using Leriche-Arnulf's approach, which he describes. This approach is also used by Garnett Passe. If properly and accurately done, the needle upon hitting the ganglion produces a sharp pain in the scapula, and upon anesthetization a Horner's syndrome.

This block is repeated twice weekly, decreasing the frequency of injections with the frequency of attacks. In bilateral cases, alternate blocks are used.

If a well-aimed stellate ganglion block is not followed by immediate improvement of tinnitus, hearing or vertigo, further injections are useless.

Two out of three cases were content with this treatment.

Only in cases not responding to medical therapy or a stellate block is labyrinthectomy done. With bilateral involvement, streptomycin therapy is employed.

The cases presented are apparently well diagnosed and selected.

E. R. Garnett Passe has a series of 88 cases in which he performs a sympathectomy for Meniere's. As a therapeutic trial he does a novocaine block of the stellate ganglion or a paravertebral block of the upper 4 or 5 thoracic ganglia. If the response is favorable, the patient showing improvement, he proceeds with sectioning the preganglionic sympathetic fibers for thoracic 2 and 3 and divides the sympathetic trunk just distal to the 3rd thoracic ganglion.

He states that 82% of the patients are completely relieved. The case histories presented are, in part, sketchy and inconclusive of Meniere's disease, as the degree and type of cochlear impairment are not given.

I should prefer Hoogland's treatment first and if it gives only temporary results, sympathectomy might be indicated.

Rosen sections the chorda tympani and supposedly stops some inhibitory stimulus to the parasympathetic via a reflex arc through the geniculate ganglion, thus producing a vasodilation. The surgical approach is simple and is similar to the Lempert tympanosympathectomy described in 1946 for tinnitus, only in Rosen's case one sections the chorda. No case histories are presented.

Destruction of the end organ is best accomplished by Lempert's or Day's technique. Complete destruction is the goal; in other words, a labyrinthectomy. Day's original procedure, desiring to maintain hearing, did not prove satisfactory because of the remaining tinnitus, distorted and unpleasant hearing, and a tendency for the vertigo to return.

The advanced cases needing this type of radical procedure on the whole do not have much useful hearing in the diseased ear because of: (1) perception deafness; (2) diplacusis with distortion of sound often making it very unpleasant; (3) recruitment or over-recruitment, causing loud sounds to reach the threshold of discomfort or pain at a much lower level than normally; (4) a poor discrimination score out of proportion to the audiometric curve—the result of a combination of the above factors.

The tinnitus is very objectionable, because it may be a combination of two or more types and is often so severe as to be a great discomfort. At times it presents a real psychosomatic problem.

The endolymphatic system has a rather marked ability to repair, at least partly, its function after injury, especially when we don't want it. This explains the occasional return of vertigo in Day's original procedure.

*Lempert's decompression operation is as follows:*

Step 1. Creation of an adequate endaural approach by enlarging the external auditory canal posteriorly and superiorly.

Step 2. Exposure of the incostapedial joint and the round window niche. This is accomplished by elevating the annulus fibrosus of the tympanic membrane from its position within the sulcus posteriorly.

Step 3. Decompression of the vestibular portion of labyrinth. The stapes is better visualized by shaving off bone from the tympanic ring with a 0000 curet. The long process of the incus is severed with a malleus clipper. The stapes is hooked out of the oval window, pulling anteriorly and laterally.

Step 4. The decompression of the cochlear portion of the labyrinth by means of a 1.5 mm. polishing burr inserted into the round window niche, destroying the round window membrane.

Step 5. Replace the drum and skin flap and pack the ear canal lightly. Keep the patient on antibiotics.

*The Day mechanical destruction and electrocoagulation of the labyrinth:*

This procedure is similar to Cawthorne's, except that he also mechanically destroys and electrocoagulates the vestibule.

Step 1. Exposure of the horizontal semicircular canal. Two endaural incisions are made without removing any skin. One incision extends from the extreme lateral aspect of the bony external auditory canal at 12 o'clock superiorly through the membranous suprameatal triangle down to the temporal muscle. The second incision starts at 6 o'clock at the external aspect of the bony external auditory canal and follows its posterior bony edge superiorly until it meets the first incision at approximately 12 o'clock. The periosteum is elevated over the temporal bone posteriorly and superiorly. The mastoid antrum is opened with a burr, leaving the bony external auditory canal. The epitympanic space is opened anteriorly. The incus is exposed and removed.

Step 2. Fenestration of the horizontal canal. The superior and lateral aspects of the horizontal canal are skeletonized with a polishing burr or a diamond burr. Magnifying glasses are used. The membranous labyrinth is soon exposed. The amputated and posterior portion of the

canal are opened widely with a polishing burr. No care is taken to preserve the membranous labyrinth.

Step 3. Destroying the labyrinth. A portion of the membranous horizontal canal, if not previously destroyed and if visible, is removed with hooks, dental broach, or forceps. An attempt is made to destroy the membranous vestibule with a dental broach. A curved coagulating needle is then passed through the amputated end of the canal medially toward the vestibule. Try to curve it around posteriorly in the vestibule to get near the amputated end of the posterior canal to destroy its nerve endings. The coagulating current is set at 20 to 25 and should be tested first on a raw surface. Three short coagulation blasts are given while counting to three. The proper control of the length and strength of coagulation is important, as in inexperienced hands it has caused facial paralysis and given this excellent technique a black eye. The fenestra may be filled with bone dust and the endaural incision carefully sutured closed. The external auditory canal is firmly packed with vaseline gauze and the patient is kept on antibiotics for one week.

Patients having had labyrinthine surgery should be encouraged to walk and practice head and body movements as soon as possible. This enables them to recover more rapidly. The cerebellum has to be reeducated.

I have performed four Day procedures, two on private patients with typical Meniere's disease and two on clinic patients who have had Meniere's syndrome following radical mastoidectomies. In the latter we did not know the pathology involving the labyrinth. We assumed that it was on the basis of a toxemia, a low-grade infection or previous operative injury to the labyrinth. I did not originally operate or closely follow these clinic patients prior to their labyrinthine surgery.

My first case was in 1945, a 35-year-old carpenter who was incapacitated by bouts of vertigo which had been occurring for five years. He had a hearing loss of about 50 db in his left ear with a typical, rather flat audiometric curve. There was marked diplacusis and recruitment present. I did the original Day operation under local anesthesia. Postoperatively his hearing was

nil in the operated ear. He had the usual imbalance, which improved greatly over a period of one month, at which time he was able to return to work. During this month's convalescence, he carried his head inclined to the operated side, evidently due to labyrinthine imbalance. He was perfectly well for two years afterward. Since then I have lost track of him.

The second case was a middle-aged woman whom I had treated for Meniere's disease for two years, when she became incapacitated. She had all the typical criteria; namely, vertigo, loss of hearing with marked fluctuations, over-recruitment, especially for C 512, diplacusis with low tones heard higher in the affected ear, and terrific tinnitus. I did Day's original procedure on her five years ago. The convalescence was extremely slow, requiring over two months. She called me about six months after the operation and said that suddenly something had happened and she could hear much better in the operated ear. I have expected her to develop symptoms, but she has been perfectly well for the past four years.

The third case was a postoperative radical mastoidectomy, a clinic case at the Medical Center. The patient had incapacitating bouts for over a year which did not respond to medical therapy; and on testing, a nerve deafness involving the low as well as the high tones on the affected side with an accompanying diplacusis. He also had a mucoid discharge from the tubal orifice. The surgical procedure involved aspirating the membranous horizontal canal and cauterizing the vestibule. The result was very satisfactory; he no longer had spells of severe vertigo.

The fourth case was at the General Hospital about two years ago, a woman. The history and the findings clinically were the same as the preceding case. On operation, the bone over the horizontal semicircular canal was stained with silver nitrate down to the endosteum. It had been used to burn down granulations in the radical cavity. Whether this was the etiological factor in producing the labyrinthine symptoms, I do not know. However, it made the fenestration much more difficult. We opened both ends of the horizontal canal very widely and cauterized

the vestibule, attempting to reach the amputated end of the posterior canal. The patient made an excellent recovery.

In conclusion, I wish to stress conservatism and accurate diagnosis. With this in mind, we will never amass a great series such as has been done in England, where Cawthorne in his first report was operating approximately 15% of his cases.

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# The Significance and Evaluation of Laboratory Data in Clinical Medicine

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**L**ABORATORY DATA is an aid or adjunct in clinical diagnosis and it alone, with the exception of the isolation of a virulent infectious agent, rarely makes the diagnosis.<sup>1</sup> Consequently, laboratory tests are never a substitute for a careful history and a thorough physical examination, and must be carefully correlated with all of the clinical findings in order to arrive at a correct diagnosis. On the other hand, it is practically impossible to practice scientific medicine without the aid of a good clinical laboratory. Generally, the physician decides which individual test or tests will be useful instead of ordering a group of laboratory tests with the hope that they will turn up a diagnosis. However, a battery or group of tests is of benefit both as simple screening tests for patients who are having a complete diagnostic workup as well as groups of suitable tests for those patients in whom study has already indicated a certain type of lesion. The screening procedures, such as urinalysis, a serological test for syphilis and the basic examinations of the blood, should always be done in conjunction with a history and physical examination of the "checkup" patient. An appropriate group of related tests done at one time on a patient with a definite disease complex, such as jaundice, anemia, or hemorrhagic disease, is usually of greater benefit than a series of tests separated by both time and therapeutic measures.

Laboratory tests are expensive and may be the source of resentment against the physician, especially if he has failed to discuss with the patient the cost of the tests, some of the pertinent details of the procedures, and the reason or necessity for doing the tests. One method of

decreasing the cost is through the use of basic screening tests and specific groups of tests which the clinical laboratory may do at one time and frequently at its convenience with a total cost to the patient which is less than the cost of the individual tests.<sup>2</sup> This has been done in several institutions and we have found it to be advantageous to both the patient and the physician. Also, laboratory data falling within normal limits is no less valuable to the patient and his physician than that showing an abnormal result. Therefore, it should not be necessary to apologize to the patient or reduce the fee for value received if the laboratory test or tests were wisely requested.

Perhaps one of the reasons that some physicians tend to rely too heavily on laboratory data in revealing the existence or non-existence of a particular disease is that the belief or acceptance in the negativity of one's findings on a physical examination is very difficult at times. Consequently, there may be a tendency to rely on laboratory data which is in concrete, numerical units and would appear to be objective, but this does not mean that it is more accurate than the subjective but very important history and the negative or equivocal physical findings. A knowledge of the variability and accuracy of the laboratory data is essential and the importance of this is epitomized in a recent statement by Ham<sup>3</sup> that there is no place in medicine for blind faith in a written figure on a patient's chart.

The accuracy of laboratory data depends on (a) the ability and training of laboratory personnel, (b) reliable equipment, (c) the proper handling of the specimens, (d) correct and prompt reporting of results, and (e) the accuracy of the test used.

Because of the shortage of trained medical

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technologists, many people are carrying out laboratory tests who have not received adequate training for their job. In order to be eligible for the examination of the Registry of Medical Technologists maintained by the American Society of Clinical Pathologists, one must have a minimum of two years of college training as well as 12 months of training in a School of Medical Technology which has been approved by the American Medical Association. Unfortunately, it is possible for a high school graduate to attend a course of several months in a proprietary school for laboratory training and then secure employment as a medical technologist. These people usually have inadequate training and background for positions of responsibility and all too frequently do not grasp the significance of many important details in a clinical laboratory. Also, this latter group has formed a Registry of their own, which only further confuses hospital administrators and personnel directors who might hire technicians without the advice or aid of a pathologist. Equally important is an adequate number of technicians, so that their work may be carried out without undue pressure or hurry, which frequently results in a marked loss in accuracy. The accuracy of a test should not be sacrificed for expediency and no laboratory data is better than an erroneous result.

### VOLTAGE INFLUENCES RESULTS

The pipettes and burettes used in the performance of a test must be calibrated accurately and this is especially true with the micropipettes that are used in the determination of hemoglobin in many laboratories. Equally important is an adequate source of constant voltage current for the operation of photoelectric colorimeters and spectrophotometers used in most biochemical procedures. Occasionally the line supplying the electric current to the laboratory also supplies an adjacent x-ray machine or other equipment and in many communities even the presence of a constant voltage transformer in the circuit from a direct line will not give a stable enough current for the satisfactory operation of these instruments. This may necessitate the use of a storage battery and failure to recognize this need will markedly influence the accuracy of the results obtained in the clinical laboratory.

The handling of a specimen is important, especially as regards the proper type of container (proper anticoagulant, cleanliness, sterility, etc.), the collection from the patient and the correct labeling of the specimen. The collection of a 24-hour urine specimen should be reviewed with both the nursing staff and the patient, since these are frequently inaccurate, especially if they are collected for several days in succession. Prompt delivery of the specimen to the clinical laboratory and immediate examination is essential in most tests. As an example, unless fluoride has been added to the anticoagulant mixture, glucose disappears from oxalated blood at room temperature at a rate of approximately 5 percent per hour,<sup>4</sup> while many other laboratory tests are altered by delay in examination of the specimen.

The reporting of the results of a test must be reliable, with the result of the test being credited to the right patient. Generally speaking, there is less error in reporting if the laboratory report is pasted directly on the hospital chart than if the laboratory data is transcribed from the individual report sheet to a consolidated data sheet. Also, any delay in the performance of the test or the reporting of the results is to be avoided, since this valuable data may alter or change the course of therapy of a patient.

The inherent variation or accuracy in laboratory tests varies considerably with the test used. An example is the variation encountered in the more common hematological tests when done on the same blood sample. (Table I.) While the data is from tests performed by trained medical students on the same blood sample of a patient with Cooley's anemia, these values compare with

TABLE I

Variation in Hematological Data from Same Blood Specimen of a Patient with Anemia (Ham<sup>3</sup>)

Determination	2 coefficients of variation
Hematocrit	± 3.4%
Hemoglobin	
Photoelectric-cell colorimeter	± 4.5%
Spencer Hemoglobinometer	± 9.0%
Haden-Hauser	± 10.0%
Sahli	± 14.0%
Tallquist	± 21.0%
Red Blood Count	
(2 pipettes, 2 chambers)	± 16.0%
(1 pipette, 2 chambers)	± 13.0%
White Blood Count	± 20.0%



the results of other investigators. The hematocrit variation is slightly larger than that of Biggs and McMillan<sup>5</sup> and Wintrobe,<sup>6</sup> who found two coefficients of variation to be  $\pm 2\%$  (the range of variation to be expected in 95 out of 100 tests), but this test has the highest degree of accuracy of any of the hematological determinations routinely used. The accuracy of the estimation of hemoglobin by a photoelectric-cell colorimeter compares favorably with the error of 4% which is generally considered to be present in the photometric determination of oxyhemoglobin and the  $\pm 3.2\%$  which is considered to be 2 coefficients of variation for the determination of hemoglobin by Biggs and Allington,<sup>7</sup> using the M.R.C. neutral-grey photometer. The remaining methods for the determination of hemoglobin depend on the direct matching of either the red color of blood or of acid hematin with an artificial color standard and a marked loss in accuracy. Also, the methods using acid hematin do not develop their maximum color until 40 minutes from the time of mixing<sup>8</sup> and the color produced is influenced by plasma.<sup>9</sup>

### ERRORS IN COUNTING

The variation in the red cell count,  $\pm 16\%$ , when 2 counting chambers of a hemocytometer were filled with different red-cell pipettes and the results averaged is the same as was found by Berkson, Magath, and Hurn,<sup>10</sup> who used one pipette and one chamber. This variation is much greater than the general conception of the accuracy of this test which is used in the calculation of many of the indices for the evaluation of red blood cells. Much better than the use of such "unreliable crutches" is an opinion of the red-cell morphology obtained by an experienced observer for examination of a stained blood smear. The error in the counting of white blood cells is even greater than that for red cells and this variation is essentially the same as the  $\pm 21\%$  found by Berkson *et al.*<sup>10</sup> Several years ago I checked the error of white blood counts as performed by 6 technicians in one of the larger hospitals in this state and found 2 coefficients of variation to be  $\pm 19.8\%$ , which again compares favorably with the  $\pm 20\%$  cited by Ham.<sup>3</sup>

The reliability and accuracy of blood chemical determinations in clinical laboratories has been found to vary considerably in several surveys.<sup>11, 12</sup> Aside from technical errors which

may be present, there is an inherent variation present in these laboratory procedures even when they are carried out under optimum conditions. As an example the error in the determination of the blood glucose level using the Folin-Wu method approaches  $\pm 10\%$ .<sup>13</sup> This accuracy is suitable for clinical use even though there are non-glucose reducing substances being measured which range from 10-30 mgm per 100 ml of blood. These do not seriously interfere with the usefulness of the test unless it is compared with a value obtained by those methods measuring only true blood glucose. However, a test of this accuracy is not suitable for the determination of some of the serum electrolytes, as, for example, serum calcium in which a  $\pm 10\%$  variation would include the entire normal range of 9-11 mgm per 100 ml. Unfortunately, the inherent error in most of the procedures for the determination of calcium is about  $\pm 5\%$ , which is an important factor in the evaluation of a given value or the changes between serial tests on the same individual. In the determination of other serum electrolyte such as sodium and potassium the accuracy is approximately  $\pm 3\%$  of the amount present, using flame spectrophotometric methods.<sup>14</sup> However, the concentration of these substances is so variable with the clinical status of the patient that careful clinical correlation is an absolute necessity. In a patient in diabetic coma before treatment, the serum potassium level may be normal or elevated even though there is total body depletion of this ion and in the edematous cirrhotic or patient with cardiac decompensation the serum sodium level is low or normal in spite of an increase in total body sodium.

Even though a laboratory test may have a high inherent error, the results obtained are useful to the clinician if he is aware of its limitations and correlates the result with the remainder of the clinical picture. Biochemical tests giving abnormal results which are inconsistent with the remainder of the laboratory data and clinical picture and which may influence the diagnosis or treatment of a patient should be repeated. If there is still doubt in the clinician's mind after repeating such tests, he should, as Kark<sup>15</sup> has recently stated, more often than not, rely on his clinical judgment rather than on the results obtained from the laboratory.

In addition to the technical variations of a test,



the concentration of the substance tested may vary in a normal individual and this must be considered when a given result is evaluated. An example of this phenomenon is seen in the determination of hemoglobin, which, as Mann<sup>16</sup> has recently stated, is not only one of the procedures most frequently requested of the clinical laboratory, but also is one whose results are questioned more frequently than almost any other. One of the reasons that the results of this test are so frequently challenged is that many of the methods used for the determination of this substance are not basically sound. Another reason is that all too frequently the concentration of hemoglobin is reported in terms of percent rather than grams per 100 ml of blood. The difficulty arises in that there is no common agreement as to what may be considered a universal 100 percent standard and the 100 percent standard of various instruments may vary from 13.8 gms to 17.2 gms per 100 ml of blood.<sup>8</sup> Consequently, if the report is not in grams per 100 ml of blood, confusion arises when the result of a laboratory using one instrument is compared to results obtained in another using a different one. However, what is usually not recognized is the variation in the hemoglobin level of the normal individual which is present during the course of a day and from day to day.<sup>17, 18</sup> Recently, Biggs and Allington<sup>7</sup> have restudied this problem and found a progressive fall in the hemoglobin values between 6 a.m. and 10 p.m., with an increase during sleep. Between 9 a.m. and 5 p.m., when most routine samples are taken, the change was not large (2-3%) and the method used was found to have an error of only  $\pm 3.2\%$  (2 coefficients of variation). On testing 20 normal subjects and 20 patients for 6-7 successive days, they were able to determine the range to be expected in testing these subjects from day to day (Table II) and found this to be much larger than the variation from the procedure alone. This variation was the same regardless of whether capillary or venous blood was used, and there was the same parallel variation in hematocrit values, which ruled out a technical error in the hemoglobin method. This variability in the concentration of hemoglobin in normal individuals must always be considered, since it cannot be distinguished by the clinician from purely technical errors.

TABLE II

Error in Estimation of Hemoglobin and Difference Between Isolated Hemoglobin Readings on One Person That Would Suggest a Real Change (Adapted from Biggs and Allington<sup>7</sup>)

Level of Hemoglobin gm %	Calculated range of 19 out of 20 observations on one individual	Significant difference* in gm % of Hemoglobin
17.8	16.7-18.8	1.5
16.3	15.1-17.5	1.6
14.8	13.5-16.1	1.8
13.3	12.0-14.7	1.9
11.8	10.5-13.2	1.9
10.4	9.0-11.7	1.9
8.9	7.5-10.2	1.8
7.4	6.2- 8.6	1.6
5.9	4.9- 7.0	1.5
4.4	3.6- 5.3	1.2
3.0	2.4- 3.6	0.9

\* Calculated from formula  $2\sqrt{2S^2}$  where S is the standard deviation.

## SUMMARY

The evaluation and significance of laboratory data in clinical medicine is dependent on the realization that not only are there possible gross technical errors in these procedures, but of equal importance are the inherent errors of a laboratory procedure as well as physiological variations in the concentration of the substance tested. Even though a test may have a high inherent inaccuracy, it may be quite useful in helping to form a clinical diagnosis if it is properly interpreted with the history and physical examination.

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*An Abstract:*

### CLINICAL SIGNIFICANCE OF ENDOMETRIOSIS

The author reviews the theories of the origin of endometriosis and finds that none of them satisfactorily explains all instances except that of metaplasia of coelomic cells. He emphasizes that the disease while benign has a capacity to spread as if malignant and that because it can occur in so many locations it can produce manifold pelvic and abdominal symptoms. He says, "the symptoms are chronic and are manifested by a month by month cumulative increase in some menstrual-linked phenomenon, usually, and most frequently, pelvic pain," and that, "when a definite nodule or cluster of nodules is palpated in the utero-sacral ligaments, with tenderness and induration, there is little doubt that pelvic endometriosis exists in most cases." Other findings he mentions are pain in inguinal regions or thighs, abdominal pain and obstipation, bladder symptoms, fever and leukocytosis.

The author emphasizes the place for conservative surgery in this condition stating that excision of the masses without castration has frequently been followed by pregnancy. In patients past the child-bearing age he sees no particular difference between castration by surgery, x-ray or radium.

Hormonal treatment of this condition he considers only palliative despite its rather extensive use by many men.

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# Common Iatrogenic Vertical Muscle Imbalances\*

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I HAVE THE PRIVILEGE of discussing with you today certain aspects of the problem of strabismus, more specifically the vertical imbalances. In considering this subject for presentation, I was struck with the realization that vertical imbalances were not always just natural aberrations but, in certain cases of my own, could sometimes be considered iatrogenic, that is, caused wholly or at least in part by me, the ophthalmologist.

Reasoning that we all have some technics in common, I have presumed that it might be interesting to review the causes and methods of correction of some of these special vertical problems with which we all have to deal from time to time.

This discussion purposely does not include the vertical misalignments resulting from gross errors in diagnosis nor from mismanagement, but rather is concerned with the unsatisfactory results that sometimes follow procedures which otherwise appear to be properly indicated, and executed according to accepted standards. It is the purpose of this paper, therefore, not to point an accusing finger at treatment failure but rather to review some of the pitfalls of good treatment.

In general, these possibly iatrogenic vertical imbalances fall into four main categories: *surgical*, *medical*, *orthoptic*, and *optical*.

## SURGICAL

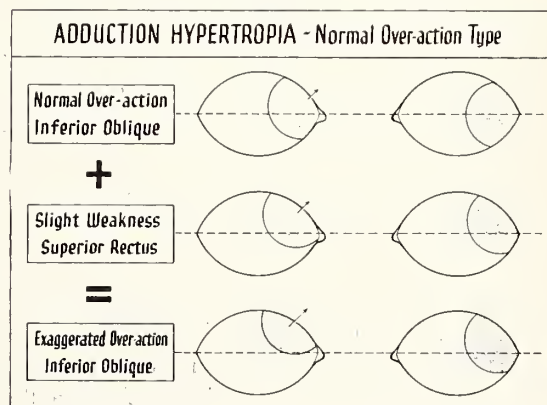
Vertical muscle imbalances are frequently associated with lateral deviations, and many surgi-

cal failures in horizontal squints may be traced to the unrecognized presence of vertical anomalies. An overacting inferior oblique associated with a horizontal squint, either convergent or divergent, is a common finding to all ophthalmologists. When this overaction is marked, it is occasionally advisable to attack the inferior oblique while operating on the horizontal muscles.<sup>1</sup> On the other hand, if the vertical imbalance is small, and the lateral deviation is large, frequently it is better to correct a portion, or all, of the lateral deviation before attempting to evaluate the vertical, which later may be influenced considerably by such surgery.

For example, a certain amount of adduction hypertropia due to overaction of the inferior oblique is frequently encountered in the extreme fields of gaze in normal individuals without strabismus. Duane<sup>2</sup> observed this, and later Scobee<sup>3</sup> referred to it as the "normal" overaction of the inferior oblique (Fig. 1).

Frequently this phenomenon is also found in patients with esotropia, and this factor may augment to a remarkable degree an otherwise small

Figure 1



\*From the Department of Ophthalmology, Indiana University Medical Center. Presented before the Indiana State Medical Association Meeting, Section on Ophthalmology and Otolaryngology, French Lick, October 21, 1953.



inferior-oblique overshoot from a mild congenital weakness of the contralateral superior rectus.

Also, in some cases of convergent strabismus of high degree, associated with a slight superior rectus weakness, the hypertropia may appear to be greater than it actually is for still another reason: the deviating eye is adducted so far that it is brought into the field of a large secondary deviation, resulting in a deceptive overshoot of the inferior oblique (Fig. 2).

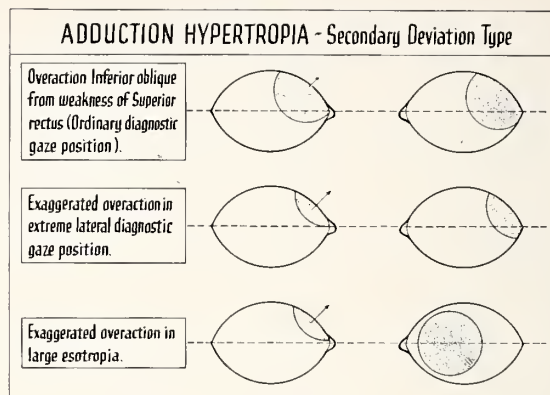
If this same superior-rectus weakness were associated with less esotropia, or with exotropia, it might fail to produce any hypertropia at all in the primary position. This also may happen when a large amount of esotropia is relieved by operation.

Consequently, if an adduction hypertropia is attacked at the time of the horizontal-muscle surgery it may unduly cripple the inferior oblique resulting in overcorrection and a consequent iatrogenic vertical imbalance. This, in turn, may contribute to the failure of an otherwise adequate horizontal correction. In many cases, therefore, it is best to disregard smaller associated vertical anomalies until after the lateral deviation has been corrected.

Vertical muscle imbalances which progress slowly to comitancy, such as congenital (or early acquired) hyperphorias, will sometimes be compensated by vertical fusional amplitudes of remarkable degree, overcoming larger and larger amounts of hyperphoria as comitance carries the imbalance into all the gaze positions. I am currently observing a patient, for example, who can overcome for hours at a time as much as 14 prism diopters of vertical imbalance by sheer force of fusional movements, with avoidance of diplopia and with binocular vision. Because of the high degree of fusional development in such patients, it is better to undercorrect than to overcorrect them, since overcorrection produces the need for vertical fusional movements in the opposite direction of those to which the patient has been accustomed. In such cases the reversed vertical measurements cause serious discomfort which is partly or wholly iatrogenic. Fortunately, these symptoms, like post-operative diplopia, tend to improve in time.

In recessions of the inferior rectus, if the muscle is dissected up out of its bed, but preserving its sheath, no deleterious effect on the

Figure 2



inferior oblique will result. Failure to do so may result in vertical imbalance.<sup>3</sup> On the other hand, this dissection must be done with full appreciation of the inferior-rectus/inferior-oblique relations; otherwise, an accidental tenotomy of the inferior oblique can result in a hypertropia of the opposite eye, particularly pronounced on looking up and laterally.

Partial tenotomy of the inferior-oblique muscle can also occur accidentally in lateral-rectus surgery, since the two muscles are frequently fused along the inferior edge of the lateral rectus in this area, and since the anterior portion of the inferior-oblique insertion can be overlooked and accidentally severed.

The correction of an underacting inferior oblique should aim at immediate post-operative overcorrection, otherwise an undercorrection is likely to result.<sup>4</sup>

Surgical, vertical imbalance may be encountered also after operating for overaction of the superior-oblique muscle, unless special care is taken to preserve the tendon sheath. Paralysis of this muscle, following tenotomy or tenectomy, results only when the sheath is also destroyed.<sup>5</sup>

In considering surgery for a permanently paralyzed lateral-rectus muscle, it is considered safe to wait 8 to 10 months for some return of function. Also, it is well to remember that the normal lateral rectus muscle is about 40 times as strong as it needs to be. It is possible, therefore, and frequently happens, that a weakened lateral rectus, opposed by a strong medial antagonist, appears to be completely paralyzed when it is not. Theoretically one might assume that if the residual function in a paretic lateral rectus is no less than one-fortieth of its original strength, surgical correction by means of recession-resec-

tion would be preferred to a Hummelsheim procedure, which may produce disturbances in vertical balance.

Surgery of the vertical rectus muscles must be more exact technically than similar surgery on the horizontal muscles; otherwise, disturbances in the positions of the lids, restrictions in the rotations of the globe, and cyclodeviations may result. Surgery of the inferior oblique, on the other hand, although mechanically more difficult, permits more technical flexibility than the other vertical muscles.

The effect of an altered surgical insertion (such as might result from a slipped suture) is much more likely to be of serious consequence in vertical than in horizontal muscles. In surgery of the vertical muscles performed for the relief of diplopia, the accident may result in a distressing increase, rather than decrease, in the patient's symptoms.

Post-operative vertical imbalances result occasionally from horizontal muscle surgery. It is possible, after the detachment of the lateral or medial rectus from its insertion, for the eye to rotate considerably without notice, and the muscles may not be reattached at the horizontal axis. Vertical displacements such as this are to be avoided ideally, but if small in amount they may cause no difficulty. Larger displacements of more than 2 or 3 mm., however, can result in cyclodeviations or vertical imbalances of clinical significance.

A traction suture (Fig. 3) oriented with the horizontal meridian near the limbus and placed at an early stage in the operation serves the double purpose of improving exposure and fixation, and provides a landmark for the new surgical insertion. Such a suture is already in use by many surgeons and is recommended especially

for those who, at times, must operate without an assistant.

## MEDICAL

In any case of external ophthalmoplegia, one must consider the differential diagnosis of congenital paralysis, brain-stem tumors, hereditary progressive external ophthalmoplegia, multiple sclerosis, and myasthenia gravis. Ocular muscle surgery is usually ill-advised in all but the first of these, congenital paralysis. The others, with the exception of myasthenia, are rare and, furthermore, will seldom mislead the operator into ocular surgery. Myasthenia, however, is more common and deserves additional comment.

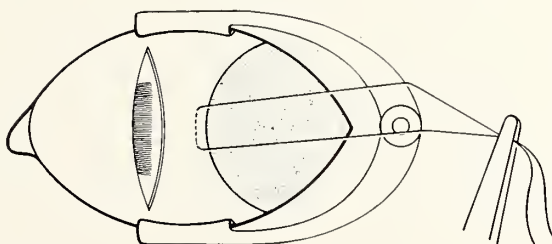
Myasthenia gravis for many years was considered a medical curiosity. Recently, however, Tether<sup>6</sup> and others have shown that it is not a rarity at all, and that the frequency of diagnosis increases when adequately sensitive methods are used to reveal the partial syndromes and milder forms of this condition. It occurs in children as well as adults.

Typical of myasthenia is ocular muscle involvement, including ptosis, a frequent and often early symptom. Although the muscles of the inner eye may occasionally be affected, they usually escape, and an external ophthalmoplegia in the presence of normal pupils usually means a myasthenic rather than neurologic condition.

Unlike neurogenic paresis, myasthenia involves the ocular muscles in a random and sometimes migratory manner, rarely even single muscles, and is subject to the characteristic remissions and exacerbations of this condition.

As would be expected, therefore, the muscle imbalances due to myasthenia gravis are both inconstant and variable, and every case of unexplained inconstant and variable strabismus should have the benefit of a myasthenia diagnostic work-up. Failing this, the ophthalmologist may perform the most exacting surgery on the extraocular muscles, correcting as nearly perfectly as possible the imbalance present, only to find later a changed motility, corresponding to the vicissitudes of the myasthenia. This applies, of course, to the horizontal muscles as well as to the vertical, but vertical imbalances are more damaging than horizontal ones, due principally to the narrow limits of vertical fusional move-

Figure 3



**Bridle suture for traction and orientation in muscle surgery of the eye.**



ments as compared with the relatively large horizontal amplitudes.

A simple diagnostic test for myasthenia gravis may be performed as an office procedure. It consists of the subcutaneous administration of 1.5 mg. of prostigmine combined with 0.6 mg. of atropine. The response is rapid and should be positive (or negative) on more than one occasion to be conclusive.

Although the subcutaneous use of prostigmine is probably adequate for the ophthalmologist, Tether<sup>6</sup> stated that he found the intravenous route superior, providing greater rapidity, more sensitivity and a more clearly defined end-point, in detecting the more subtle cases of myasthenia gravis.

### ORTHOPTIC

Some congenital weaknesses of the vertical muscles may cause no subjective symptoms for many years. This frequently is seen when a superior rectus weakness, for example, is so mild that there is no significant vertical imbalance except in the diagnostic field of gaze. With good fusion, patients may tolerate such vertical imbalances for years, although most cases eventually develop symptoms due to the almost inevitable spread of comitance from the originally affected field to the other fields of gaze.

This development of comitance is due to several factors, the most important of which are: contractures in the antagonist muscle, hypertrophy of the yoke muscle, and inhibition of the contracted antagonist's yoke muscle. These factors depend somewhat upon muscle activity for their development, and although the spread of comitance is inevitable in time, it can be accelerated by ocular exercise.

It is therefore understandable how an incomitant, but asymptomatic, vertical anomaly can sometimes be transformed into a troublesome vertical imbalance by a few weeks of intensive exercise as, for example, on the Rotoscope. Under such circumstances, symptoms may develop where there were none before, some patients relapsing from relative comfort to discomfort or sudden diplopia.

Intensive eye-use may produce a similar result in these patients, and I have in mind a young man who precipitated a rapid spread of comitance by taking a summer job which involved

copying from one ledger to another. By the end of the summer the patient had developed diplopia, and later progressed gradually to a large hypertropia in the primary position.

Comitance spread sometimes may be accelerated by patching for amblyopia, if there is an associated incomitant vertical imbalance, and if the amblyopic eye is paretic. When the paretic eye is forced to fix, a secondary deviation in the other eye results, favoring the spread of comitance.

In these special circumstances, then, imbalances which are at least partly iatrogenic may follow the use of exercise or occlusion, detracting, of course, not at all from the value of these otherwise useful orthoptic procedures.

Prolonged (Marlow) occlusion for diagnostic purposes has also been implicated in the development of hyperphoria and hypertropia, but it seems unlikely that this occurs as a complication of the procedure, except in the manner just described for small or latent vertical imbalances confined to one field of gaze but becoming comitant as a result of a secondary deviation during the occlusion. Moreover, persons with normal muscle balance may be subjected to monocular occlusion for long periods without developing demonstrable heterophoria.

### OPTICAL

The law of decentration of lenses states that prism power is induced by an ordinary dioptric system when the lenses of the system are decentered. Quantitatively this may be expressed:

$$\Delta = D \times Cm$$

where D is the dioptric strength of the lens in the meridian of decentration, and Cm is the amount of decentration in centimeters.

Prisms induced in spectacles by horizontal dysjunctive movements of the eyes are, of course, important considerations in the prescription and fitting of glasses, but as a rule patients will tolerate much more prism induced horizontally than vertically; consequently, iatrogenic vertical imbalances of optical type are frequently associated with spectacle discomfort.

Close attention to two factors, namely, facial asymmetry and anisometropia, will provide the key to comfort in these vertical cases.

Facial asymmetry, with one pupil higher than the other, may induce a vertical prismatic effect if the lenses are not decentered to conform to



this asymmetry. The correction of this factor, of course, is more often the problem of the optician rather than that of the ophthalmologist, and, fortunately, in any event, is not frequently encountered in clinically significant amounts.

A common cause of induced vertical imbalance is anisometropia. Unless otherwise specified on the prescription, the spectacles of these patients will be centered as usual for the distance PD. This allows for the alignment of each optical center with each pupil, an arrangement which, unfortunately, is homocentric only for primary distance gaze. It often becomes significantly heterocentric for downward gaze, since the reading centers are (on the average) 2 mm. in, and 8 mm. down, from the distance centers. When the refraction is bilaterally equal, the same prism is induced before both eyes, producing no discomfort. If the patient is wearing lenses of unequal strength, however, a vertical imbalance will be induced when the patient looks down to read. When the difference between the two eyes is 1.25 diopters, the patient will have an artificially-induced vertical imbalance of 1 prism diopter for reading. This is enough to cause discomfort in many patients, and some patients will complain of as little as  $\frac{1}{2}$  prism diopter of vertical imbalance. This is especially true if the base direction happens to aggravate an already existing vertical phoria.

It is to be emphasized that these vertical imbalances are the same whether the patient is wearing single-vision or bifocal lenses. The discomfort, however, is usually greater with bifocals since the patient is obliged to lower his gaze the full amount for reading. The problem is therefore not entirely, but mostly, confined to presbyopic patients.

In the correction of these vertical artefacts, it is not enough to prescribe a decentration of one of the lenses, since this simply replaces one vertical imbalance with another or, at best, results in a compromise at both the near and distance positions.

The choice of a method of correction depends upon the amount of imbalance and the type of bifocal used but will utilize one of the following: slab-off, prism bifocal segments, or dissimilar bifocal segments.

The slab-off method can be used with any type of bifocal segment and with plus or minus lenses.

A plane facet is ground on the front surface of one lens in its lower portion, creating prism base up in the area of the bifocal segment. The slab-off is made on the lens with the more minus or less plus. For vertical imbalances of more than 1 prism diopter this method is especially satisfactory. For example, to calculate the vertical imbalance resulting from the prescription:

$$-1.25 + 2.00 \times 90$$

$$-2.75 + 2.50 \times 90$$

the cylinders are disregarded because of their 90-degree axis, but the difference between the spheres is 1.50 diopters. This, multiplied by the decentration of the reading centers (0.8 cm. down from the distance centers) is the amount of vertical imbalance between the two lenses, in this instance  $1.2\Delta$  ( $1.5 \times 0.8$ ) base down in the left eye. Unless the patient happens to have a left hyperphoria, he will usually suffer dis-

VERTICAL AND HORIZONTAL IMBALANCES  
CAUSED BY OBLIQUE AXIS CYLINDERS

R.E.			L.E.		
AXIS	VERT.	HOR.	VERT.	HOR.	AXIS
90	.000	.20 out	.000	.20 out	90
85	.02	.28 out	.01	.13 out	85
80	.06	.34 out	.01	.06 out	80
75	.11	.40 out	.000	.000	75
70	.16	.44 out	.02	.07 in	70
65	.22	.48 out	.06	.13 in	65
60	.29	.50 out	.11	.18 in	60
55	.36	.52 out	.16	.23 in	55
50	.43	.52 out	.22	.27 in	50
45	.50	.50 out	.29	.29 in	45
40	.57	.48 out	.36	.30 in	40
35	.63	.44 out	.43	.30 in	35
30	.69	.40 out	.50	.27 in	30
25	.74	.34 out	.57	.27 in	25
20	.77	.28 out	.63	.23 in	20
15	.80	.26 out	.69	.18 in	15
10	.81	.14 out	.74	.13 in	10
5	.81	.07 out	.77	.07 in	5
180	.80	.000	.80	.000	180
175	.77	.07 in	.81	.07 out	175
170	.74	.13 in	.81	.14 out	170
165	.69	.19 in	.80	.26 out	165
160	.63	.23 in	.77	.28 out	160
155	.57	.27 in	.74	.34 out	155
150	.50	.27 in	.69	.40 out	150
145	.43	.30 in	.63	.44 out	145
140	.36	.30 in	.57	.48 out	140
135	.29	.29 in	.50	.50 out	135
130	.22	.27 in	.43	.52 out	130
125	.16	.23 in	.36	.52 out	125
120	.11	.18 in	.29	.50 out	120
115	.06	.13 in	.22	.48 out	115
110	.02	.07 in	.16	.44 out	110
105	.000	.000	.11	.40 out	105
100	.01	.06 out	.06	.34 out	100
95	.01	.13 out	.02	.28 out	95
90	.000	.20 out	.000	.20 out	90

Calculated for +1.00 D cylinder. All vertical figures are base up. Horizontal as marked. In using this chart, transpose all cylinders to plus.

Figure 4 (Wilson)—(From Practical and Physiological Optics, p. 52, House of Vision, Chicago, 1942.)

comfort from this amount of imbalance. Relief is obtained by the simple expedient of ordering, in this case, 1.2Δ slab-off of the left lens at the time of the prescription.

The above example involves only the spherical correction. In other instances, however, it is necessary to calculate the prismatic effects of all cylinders which are not at the 90-degree meridian. For cylinders, axis 180, the prismatic effect in the vertical meridian is the same as if this cylinder were a sphere. Cylinders placed at oblique axes have both a vertical and a horizontal spherical component, but only the vertical is to be included in the calculation of these vertical imbalances. Tables are available which simplify the otherwise tedious calculation of these vertical prismatic effects arising from oblique axis cylinders, (Fig. 4).

Prism segments can be obtained in some bifocals of the fused type, and the prism is ground into the segment only. This is not entirely practical with Ful-Vue or Univis nor with one-piece bifocals because of the overhanging shoulder resulting at one edge. For vertical imbalances up to 1.5 prism diopters, however, the Panoptik bifocal can be made satisfactorily with prism incorporated in the segment only.

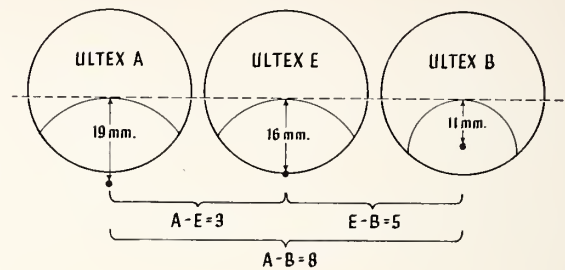
Panoptik bifocals, although excellent, are not always desirable, and slab-off is occasionally objectionable in appearance to the patient. In these cases, when the imbalance is about one prism diopter or less, dissimilar one-piece (Ultex) segments may be used to correct the vertical imbalance.<sup>7</sup> Cosmetically this method of satisfactory and the dissimilarity in segments is not ordinarily noticeable.

The method utilizes the fact that various types of bifocal segments have differently placed optical centers. These centers vary from a position at the top of the segment to one which is located actually outside the lower border of the segment.

By using a different type of segment for each eye a decentration is obtained amounting to the difference in height of the optical centers of the two segments. This difference expressed in centimeters, and multiplied by the dioptric strength of the reading addition, is the amount of compensating prismatic effect.

The distance in millimeters from the top of the bifocal segment down to the optical center is as follows in these Ultex types: A, 19; E, 16; and B, 11 (Fig. 5). It is possible therefore to

Figure 5



obtain the following differences in height of the optical centers of these segments by using these combinations: A-E, 3 mm.; E-B, 5 mm.; and A-B, 8 mm., providing 0.3Δ, 0.5Δ, and 0.8Δ, respectively, for the various combinations, and for each diopter of reading addition.

Let us suppose that a patient wears the following prescription:

$$+2.00 + 1.00 \times 90$$

$$+1.00 + 1.00 \times 90$$

Add +1.00, O.U.

in which case 0.8 prism diopter of vertical imbalance is induced at the reading position. To compensate for this, a combination of dissimilar segments using Ultex A for the right eye and Ultex B for the left eye, making a vertical difference in optical centers of 8 mm., provides 0.8Δ base down, right eye, which neutralizes exactly the vertical imbalance induced by the prescription at the reading position.

## SUMMARY

It is to be emphasized that the iatrogenic vertical imbalances discussed here may often arise in spite of otherwise good ophthalmologic practice, a fact which need not be surprising in this specialty of refinements and perfectionism.

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# Cesarean Section Rates in Indiana

## (A Follow-up Study)

THESE STATISTICS are presented by the Committee on Maternal and Child Health, Indiana State Medical Association in cooperation with the Division of Maternal and Child Health, Indiana State Board of Health. They have been compiled for the medical profession and the medical staffs of the hospitals in Indiana and the study will be a continuing one, a sequel to two previous reports, "Maternal, Newborn and Premature Infant Care, and Cesarean Sections in Indiana Hospitals,"<sup>1</sup> and "Cesarean Section Rates in Indiana."<sup>2</sup>

The data show that there is an obvious variation in the Cesarean section rates of different

hospitals in Indiana, which should be of interest to hospital medical staffs.

Since this study has been made for four consecutive years (1949-1952), the statistical charts, shown at the end of the article, which depict the distribution of change in Cesarean birth rate, the distribution of Cesarean birth percentage by number of hospitals, and the distribution of Cesarean birth rate by the size of the hospital, are graphic and enlightening.

The Committee on Maternal and Child Health has recommended that this study be repeated biennially so that current statistics will be available to physicians in Indiana for the Cesarean section rates of all hospitals in the state.

### CESAREAN SECTION RATES IN INDIANA

#### By Hospitals

1949, 1950, 1951 and 1952

HOSPITAL AND LOCATION	1949 Percent Sections	1950 Percent Sections	Live Births	1951 Cesarean Sections	Percent Sections	Live Births	1952 Cesarean Sections	Percent Sections
TOTALS (State of Indiana)	4.13	4.18	94,271	3,700	3.92	95,675	3,802	3.98
Adams County								
Decatur								
ADAMS COUNTY MEMORIAL	5.91	6.96	701	40	5.7	710	23	3.2
Allen County								
Fort Wayne								
FT. WAYNE METHODIST	2.20	2.24	1,108	10	0.9	1,150	17	1.5*
LUTHERAN OF FT. WAYNE	3.15	3.53	2,106	51	2.4	1,927	49	2.5*
ST. JOSEPH	1.98	3.03	1,928	43	2.2	2,234	48	2.2
Bartholomew County								
Columbus								
BARTHOLOMEW COUNTY	2.77	2.47	1,008	27	2.7	1,006	35	3.5
Blackford County								
Hartford City								
BLACKFORD COUNTY	2.14	4.40	394	14	3.6	411	12	2.9
Boone County								
Lebanon								
WITHAM MEMORIAL	2.99	3.06	733	26	3.5	722	20	2.8

<sup>1</sup> Journal of the Indiana State Medical Association, November, 1947.

<sup>2</sup> Journal of the Indiana State Medical Association, September, 1951.



HOSPITAL AND LOCATION	1949 Percent Sections	1950 Percent Sections	Live Births	1951 Cesarean Sections	Percent Sections	Live Births	1952 Cesarean Sections	Percent Sections
Cass County								
Logansport								
CASS COUNTY MEMORIAL	6.97	7.84	535	36	6.7	538	30	5.6
ST. JOSEPH	3.09*	3.61	591	12	2.0	590	18	3.1
Clark County								
Jeffersonville								
CLARK COUNTY MEMORIAL	5.15*	3.60	901	35	3.9	865	32	3.7
Clay County								
Brazil								
CLAY COUNTY	6.64	5.20	442	21	4.8	424	22	5.2
Clinton County								
Frankfort								
CLINTON COUNTY	3.11	2.76	586	19	3.2	587	22	3.8
Daviess County								
Washington								
DAVIESS COUNTY	9.35	10.52	865	90	10.4	884	48	5.4
Decatur County								
Greensburg								
DECATUR COUNTY MEMORIAL	12.65	12.82	434	46	10.6	437	44	10.1
DeKalb County								
Auburn								
DR. BONNELL M. SOUDER	1.98	3.19	162	2	1.2	73	2	2.7*
SANDERS GENERAL	3.05	2.52	79	2	2.5*	114	3	2.6
Garrett								
SACRED HEART	2.93	3.17	455	12	2.6	439	12	2.7
Delaware County								
Muncie								
BALL MEMORIAL	3.18	4.35	2,231	95	4.3*	2,481	118	4.8
Dubois County								
Jasper								
MEMORIAL OF DUBOIS COUNTY (new)			127	7	5.5*	426	15	3.5
Huntingburg								
THE STORK	6.80	5.37	596	14	2.3	427	23	5.4
Elkhart County								
Elkhart								
ELKHART GENERAL	4.08	3.09	1,467	43	2.9	1,545	63	4.1
Goshen								
GOSHEN	5.21	7.04	740	41	5.5	756	56	7.4
Fayette County								
Connersville								
FAYETTE MEMORIAL	3.02	4.15	726	34	4.7	652	28	4.3
Floyd County								
New Albany								
ST. EDWARD	4.68	4.48	1,376	63	4.6	1,385	64	4.6
Fulton County								
Rochester								
WOODLAWN	12.60	12.20	488	58	11.9	487	59	12.1
Gibson County								
Princeton								
GIBSON GENERAL	1.86	1.39	586	8	1.4	523	1	0.2
Oakland City								
(OAKLAND CITY (after 3-52)	0.57	2.22*	123	2	1.6			
(WOOD HOSPITAL (prior to 3-52)						77	0	0.0*

HOSPITAL AND LOCATION	1949 Percent Sections	1950 Percent Sections	Live Births	1951 Cesarean Sections	Percent Sections	Live Births	1952 Cesarean Sections	Percent Sections
Grant County								
Marion								
MARION GENERAL	3.13	4.06	1,299	56	4.3	1,375	52	3.8
Greene County								
Linton								
FREEMAN-GREENE COUNTY	19.39	18.02	521	87	16.7	579	86	14.9
Hamilton County								
Noblesville								
HAMILTON COUNTY	6.95*	9.11	337	23	6.8*	571	33	5.8
Hancock County								
Greenfield								
HANCOCK CO. MEMORIAL (new)						386	16	4.1
Harrison County								
Corydon								
HARRISON COUNTY		3.73*	189	4	2.1	261	4	1.5
Henry County								
New Castle								
HENRY COUNTY	4.05	4.46	1,049	42	4.0*	752	25	3.3*
Howard County								
Kokomo								
ST. JOSEPH	3.71	3.71	1,472	49	3.3	1,413	46	3.3
Huntington County								
Huntington								
HUNTINGTON COUNTY	1.44*	1.32	687	11	1.6	745	8	1.1
Jackson County								
Seymour								
JACKSON CO. SCHNECK MEMORIAL	4.95	4.66	835	51	6.1	897	43	4.8
Jasper County								
Rensselaer								
JASPER COUNTY	6.82	6.01	510	33	6.5	545	33	6.1
Jay County								
Portland								
JAY COUNTY	18.38	16.70	491	66	13.4	519	48	9.3
Jefferson County								
Madison								
KING'S DAUGHTERS'	4.62	6.12	648	30	4.6	660	23	3.5
Johnson County								
Franklin								
JOHNSON COUNTY MEMORIAL	2.53	1.22	650	15	2.3	710	15	2.1
Knox County								
Vincennes								
GOOD SAMARITAN	3.83	3.74	993	42	4.2	950	46	4.8
Kosciusko County								
Warsaw								
MC DONALD	2.06	1.44	438	20	4.6	95	3	3.2*
MURPHY MEDICAL CENTER	6.15	7.00	232	13	5.6	242	8	3.3
LaGrange County								
LaGrange								
LA GRANGE COUNTY		8.33*	369	10	2.7	411	11	2.7
Lake County								
East Chicago								
ST. CATHERINE	3.19	3.31	2,320	91	3.9	2,368	90	3.8
Gary								
METHODIST OF GARY, INC.	2.59	2.95	3,287	94	2.9	3,573	101	2.8
ST. MARY'S MERCY	2.56	2.28	2,250	65	2.9	2,476	67	2.7
Hammond								
ST. MARGARET	2.73	3.40	3,070	115	3.7	3,202	117	3.7

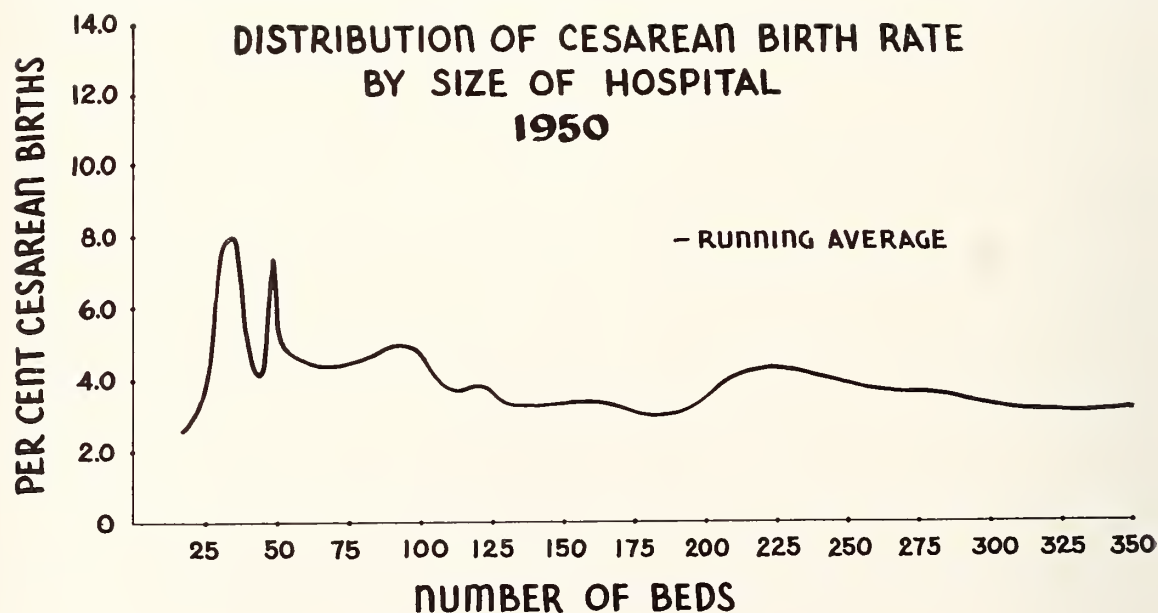
HOSPITAL AND LOCATION	1949	1950	Live Births	1951	Percent Sections	Live Births	1952	Percent Sections
	Percent Sections	Percent Sections		Cesarean Sections			Cesarean Sections	
LaPorte County								
LaPorte								
FAIRVIEW	8.73	8.24	813	58	7.1	728	50	6.9
HOLY FAMILY	3.21	5.72	571	30	5.3	446	26	5.6
Michigan City								
(CLINIC HOSPITAL was changed to (DOCTOR'S HOSPITAL in 1951	11.70	13.86*	141	4	2.8*	78	0	0.0*
ST. ANTHONY	4.06	3.50	854	28	3.3	820	28	3.4
Lawrence County								
Bedford								
DUNN MEMORIAL	5.78	5.42	909	42	4.6	975	69	7.1
Madison County								
Anderson								
ST. JOHN'S HICKEY MEMORIAL	9.12	9.66*	2,040	103	5.0	2,092	127	6.1
Elwood								
MERCY	1.76	1.94	514	13	2.5	513	8	1.6
Marion County								
Beech Grove								
ST. FRANCIS	1.27	0.83	2,418	32	1.3	2,563	33	1.3
Indianapolis								
INDIANAPOLIS GENERAL	3.14	3.10	1,476	43	2.9	1,649	43	2.6
I. U. MEDICAL CENTER	5.67	6.33	1,921	107	5.8	2,765	141	5.1
METHODIST	5.01	3.95	6,251	261	4.2	6,142	289	4.7
ST. ELIZABETH MATERNITY	0.00	0.00	21	0	0.0	35	0	0.0
ST. VINCENT'S	3.37*	3.19*	2,987	89	3.0	455	16	3.5*
Marshall County								
Argos								
KELLY	0.00*							
Bremen								
COMMUNITY	0.00*	0.00*	253	0	0.0	263	0	0.0
Plymouth								
PARKVIEW	1.80	2.33*	467	14	3.0	426	20	4.7*
Miami County								
Peru								
DUKES-MIAMI COUNTY	3.50*	6.30	472	19	4.0*	642	22	3.4
Monroe County								
Bloomington								
BLOOMINGTON	5.57	5.98	1,223	73	6.0	1,250	79	6.3
Montgomery County								
Crawfordsville								
MONTGOMERY CO. CULVER UNION	3.73	3.69	859	27	3.1	920	21	2.3
Morgan County								
Martinsville								
MORGAN COUNTY MEMORIAL	0.33*	0.82	356	3	0.8	405	3	0.7
Noble County								
Kendallville								
MC CRAY MEMORIAL	8.68	7.79	420	39	9.3	385	29	7.5
Wolflake								
LUCKEY	1.81	2.78	144	1	0.7*	182	14	7.7
Orange County								
Paoli								
CLARK (No reports 1951 & 1952)	0.00*							
Perry County								
Tell City								
PARKVIEW	0.51	0.00*						
PERRY COUNTY		0.00*	354	6	1.7	388	4	1.1



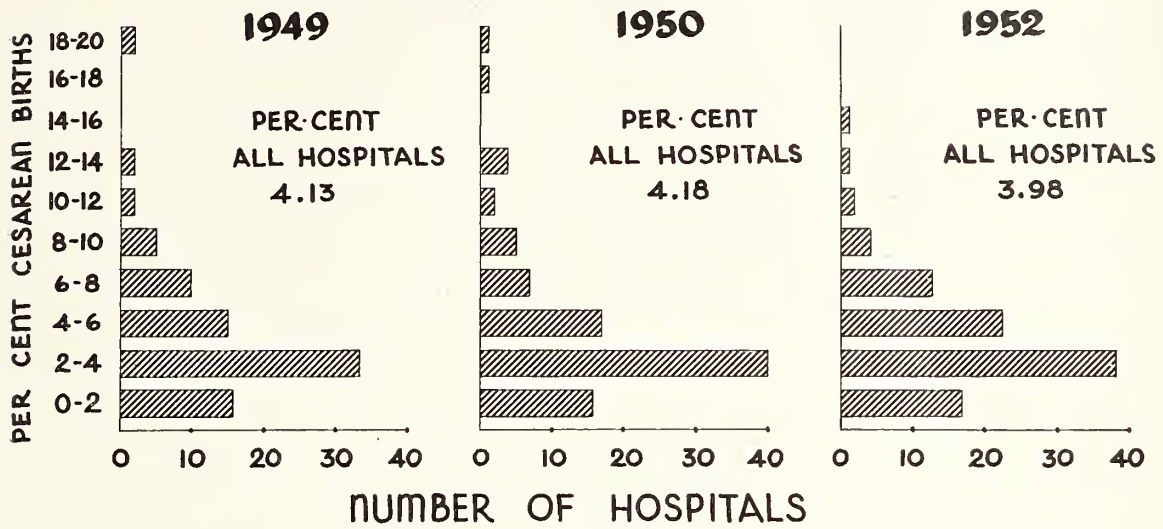
HOSPITAL AND LOCATION	1949 Percent Sections	1950 Percent Sections	Live Births	1951 Cesarean Sections	Percent Sections	Live Births	1952 Cesarean Sections	Percent Sections
Porter County								
Valparaiso								
PORTER MEMORIAL	3.45	2.96	788	20	2.5	812	31	3.8
Pulaski County								
Winamac								
CARNEAL'S PRIVATE	0.00	1.57*	137	3	2.2	135	0	0.0
Putnam County								
Greencastle								
PUTNAM COUNTY	3.61	2.95	433	16	3.7	508	25	4.9
Randolph County								
Union City								
UNION CITY MEMORIAL	11.38	10.78*	234	23	9.8	203	20	9.9
Winchester								
RANDOLPH COUNTY	8.57	12.39*	144	12	8.3*	415	38	9.2*
Ripley County								
Batesville								
MARGARET MARY	1.79	1.51	814	18	2.2	774	13	1.7
Milan								
WHITLATCH CLINIC	2.81	2.32	319	7	2.2	353	20	5.7
Rush County								
Rushville								
RUSH MEMORIAL		3.17	455	12	2.6	483	9	1.9
RUSHVILLE CITY	2.76*							
St. Joseph County								
Mishawaka								
ST. JOSEPH	2.29	1.87	1,117	19	1.7*	1,206	16	1.3
South Bend								
MEMORIAL OF SOUTH BEND	7.35*	5.84*	2,546	136	5.3	2,673	131	4.9
ST. JOSEPH	2.95	3.70	1,928	71	3.7	1,971	56	2.8
SOUTH BEND OSTEOPATHIC	3.61*	3.31	493	17	3.4	564	18	3.2
Scott County								
Scottsburg								
NAPPER	0.00	0.00*	41	1	2.4*	217	0	0.0*
Shelby County								
Shelbyville								
WILLIAM S. MAJOR	3.23	3.33	706	23	3.3*	711	26	3.7
Starke County								
Knox								
STARKE CO. MEM. (New - 1-52)						404	20	4.9
Steuben County								
Angola								
CAMERON	3.74	4.88	147	2	1.4*	208	3	1.4
ELMHURST	0.54	2.52	186	5	2.7	140	2	1.4
Sullivan County								
Sullivan								
MARY SHERMAN	1.54	1.98	496	13	2.6	516	13	2.5
Tiptecanoe County								
Lafayette								
LAFAYETTE HOME	4.30	4.56	1,245	59	4.7	1,283	81	6.3
ST. ELIZABETH	3.16	2.68	1,495	47	3.1	1,482	41	2.8
Tipton County								
Tipton								
BURKHART EMERGENCY	0.00							
TIPTON COUNTY MEMORIAL		0.00*	355	10	2.8*	409	30	7.3

HOSPITAL AND LOCATION	1949	1950	Live Births	1951	Percent Sections	Live Births	1952	Percent Sections
	Percent Sections	Percent Sections		Cesarean Sections			Cesarean Sections	
Vanderburgh County								
Evansville								
PROTESTANT DEACONESS	2.37*	3.05*	2,420	73	3.0	2,540	56	2.2
ST. MARY'S	2.91	2.27	1,308	23	1.8	1,367	40	2.9
WELBORN MEMORIAL BAPTIST	7.17	4.77	1,036	46	4.4	1,090	56	5.1
Vermillion County								
Clinton								
VERMILLION COUNTY	6.84	4.34	549	28	5.1	539	33	6.1
Vigo County								
Terre Haute								
FLORENCE CRITTENTON HOME	0.00*							
HOOVER SANATORIUM	3.28*	0.00*	21	0	0.0*	13	1	7.7*
ST. ANTHONY	2.02	2.05	1,259	24	1.9	1,085	14	1.3*
UNION	3.49	6.19	1,276	56	4.4	1,341	68	5.1
Wabash County								
Wabash								
WABASH COUNTY	6.28	8.15	609	48	7.9	622	50	8.1
Warren County								
Williamsport								
COMMUNITY	0.00	0.00*	158	8	5.1*	179	6	3.4
Washington County								
Salem								
WASHINGTON COUNTY								
MEMORIAL		7.14*	338	14	4.1	333	19	5.7
Wayne County								
Richmond								
REID MEMORIAL	4.85	2.96	1,906	81	4.2	1,692	83	4.9
Wells County								
Bluffton								
CLINIC	2.70	0.70*	132	4	3.0*	150	1	0.7
WELLS COUNTY	3.80	3.53	348	15	4.3	345	12	3.5
Whitley County								
Columbia City								
WHITLEY COUNTY MEMORIAL			233	6	2.6*	190	9	4.7*

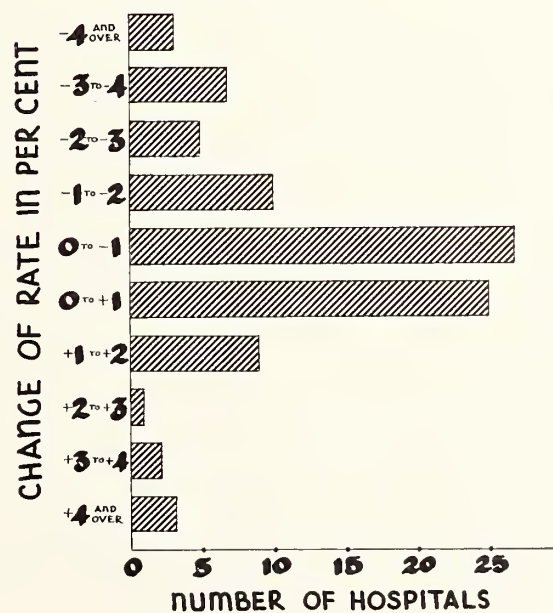
\* Estimated from Incomplete Reports.



# DISTRIBUTION OF CESAREAN BIRTH PERCENTAGE BY NUMBER OF HOSPITALS



## DISTRIBUTION OF CHANGE IN CESAREAN BIRTH RATE BY NUMBER OF HOSPITALS 1950 - 1952





# The *Journal*

of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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## STATE HEALTH COMMISSIONER

ON SEPTEMBER FIRST, Doctor Leroy E. Burney, having been recalled to duty with the United States Public Health Service, vacated his assignment as State Health Commissioner and Secretary of the Indiana State Board of Health.

Doctor Burney has served as head of the state health service since 1945 in an outstanding manner. He is a native Hoosier and received his entire formal education in this state, and was awarded the M.D. degree from Indiana University School of Medicine in 1930.

When he was appointed as State Health Commissioner in 1945 he brought the experience of 14 years with the U. S. Public Health Service, and has carried out his duties and responsibilities with a high degree of tact and diplomacy.

He is to be stationed in Washington, D. C., with the grade of Assistant Surgeon General, and will be Deputy Chief of the Bureau of State Services. His new task will allow him full use of the experience he has accumulated in Indiana during the last nine years.

The Council of the State Association, at its summer meeting, formally recognized Doctor Burney's contributions to public health in Indiana and wished him Godspeed and every success in his new work. The medical profession joins in this expression of thanks and good wishes.

Doctor Burney will be succeeded by Doctor Andrew C. Offutt. Doctor Offutt is also a native of the state, born in Johnson county. He resided in Henry county, attended Franklin College, and graduated from Indiana University School of Medicine in 1940.

He was first associated with the Indiana State Board of Health as Director of Communicable Disease Control in 1951, after 10 years' service with the United States Army. He has recently been Chief of the Bureau of Preventive Medicine. His experience and previous service as one of Doctor Burney's chief assistants recommends him for the position. He has assumed his new duties with the best wishes of the entire profession.

## THE BEAUMONT MEMORIAL

A SHRINE TO ONE of the heroes of American medical research was dedicated on July 17 by the medical profession of the state of Michigan. The building is a reconstruction of the original American Fur Company store in which Alexis St. Martin was accidentally wounded in 1822. Here it was that William Beaumont, at that time a medical officer of the United States Army, treated the wounded French-Canadian, and enabled him to survive.

Later, when the wound had healed, with a resulting gastric fistula, Dr. Beaumont carried out the now famous series of observations and experiments which laid the foundation for the modern knowledge of gastric digestion. So well was the investigation done that almost none of its conclusions have been found in error. For many years Beaumont's work comprised the only known facts concerning physiology of the stomach.

The building was reconstructed with funds contributed by the doctors of Michigan and was given by them to the people of Michigan as a museum and monument to the pioneering and investigative spirit of a great American physician.

William Beaumont's medical education was gained by preceptorship and by his own efforts; a common method of training in those days. He was never enrolled in a medical school. In spite of this, or maybe partially because of it, he possessed the investigative spirit, and the scientific curiosity, and the zeal necessary for completion of a piece of clinical research which is still authentic.

Other cases of gastric fistula were reported prior to that time; some by medical centers where laboratory facilities would have made the

research easy by comparison. However, it remained for Beaumont, equipped with only a thermometer, test tubes and a sand bath to produce the work for which he is justly famous.

Nothing seemed to interfere with his work. St. Martin was moody and frequently was surly and difficult to manage. Dr. Beaumont took advantage of this turn of events to study the effect of emotions on the process of digestion. St. Martin was addicted to strong drink, and when he was drunk from too much whiskey, Dr. Beaumont studied the effect of alcohol on the stomach.

Beaumont has been honored and dignified many times. It was on one of these occasions in 1902 that Sir William Osler said of him: "But he has a far higher honour than any you can give him here—the honour that can only come when the man and the opportunity meet, and match. Beaumont is the pioneer physiologist of this country, the first to make an important and enduring contribution to this science. His work remains a model of patient, persevering investigation, experiment and research, and the highest praise we can give him is to say that he lived up to and fulfilled the ideals with which he set out and which he expressed when he said: 'Truth, like beauty, when "unadorned, is adorned the most," and, in prosecuting these experiments and inquiries, I believe I have been guided by its light.'"

William Beaumont was indefatigable. He was a brilliant investigator. He set the pattern for American medical research. The medical profession of the state of Michigan can be proud of him and of the memorial which has been erected in his honor.

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## OLDER PEOPLE BELONG

GERIATRICS AS A SPECIALTY was inevitable as a result of medical advances, particularly in the last 20 years. With the rapid increase of older and more vigorous older people

in the country, unanticipated problems confront society at the present time. Modern treatment methods keep the old people in a fairly good state of health. This state in turn requires a

sense of security, usefulness, and, of necessity, these people face an economic question of how to get along, how to make ends meet.

It is ironical that in this country the Social Security laws were passed just a few years prior to the major advances in medicine, particularly the development of antibiotics and later the development of cortisone, ACTH, etc. At that time Social Security was looked upon merely as a means of tiding the old man over a few years for what was at best a miserable existence. In addition, the recipient was limited as to supplemental income by law to a mere pittance.

Another disturbing factor to the aged is forced retirement at an arbitrary age, in most cases at age of 65. In many cases, individuals arriving at that age now are vigorous and capable of doing a good day's work, but they are forced to step out. This enforced idleness is usually conducive to unhappiness and a feeling of not belonging, a sense of being superfluous. The enforced leisure, instead of being the blessing it was thought to be, is nothing but a crippling sense of ennui.

It is the opinion of the writer that the time has come for a change in our thinking. We must look upon the aging not as transients who are merely waiting for their departure, but as citi-

zens older in years to be sure, who require a little more rest than usual, whose tasks might perhaps have to be lightened a bit, but who are still capable of participating in the world's work and doing their share. The first step that is necessary to make happier the lot of old people is to individualize retirement. We should do away with the arbitrary age limit. If a man of 65 or older is capable of doing his work satisfactorily, he should remain employed. The next step is to change our point of view about the Social Security payments. This must be looked upon as merely supplementary to a man's earnings instead of the other way around. In other words, the older individual should be permitted to work in accordance with his capacities or skills regardless of Social Security payments.

These two steps would go a long way in assuring older people their place in the sun. They will feel then that they belong; that they are citizens doing their share of the work and entitled to full partnership in the life of the community. It will give them the peace of mind which they need to carry on and consider themselves worthy citizens.

—Max H. Weinberg, M.D.

The Pennsylvania Medical Journal

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## THE FIVE-DAY HOSPITAL WEEK

IT SEEMS as if but yesterday that hospitals functioned twenty-four hours a day and seven days a week. However, since the second World War, there have been serious changes in the management of hospitals and at amazing speed, so much so that the average doctor is at a loss when confronted with ever-changing innovations instituted in many hospitals. Among the changes now prevailing in the vast majority of hospitals, especially in the larger cities, is the establishment of the five-day hospital week. The pathologic and clinical laboratories, the x-ray department, the social service department, the administrative department, and many other departments function five days a week. Only a skeletal force of interns and residents is to be

found in most hospitals on Saturdays and Sundays. It must be remembered that change and progress are not synonymous. It would be well for all of us to stop and to evaluate the consequences of the five-day hospital week. Many serious-minded doctors are beginning to complain that their patients are inadequately treated in the hospitals on week ends. Patients are complaining that they receive no treatment on week ends while in the hospital, and many of them protest that they are unjustly charged for these two days since nothing is being done for them at that time.

—Bulletin of the Medical Society  
of the County of Kings, New York



# Dramamine's® Effect in Vertigo

*Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.*

Vertigo, according to Swartout, is primarily due\* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

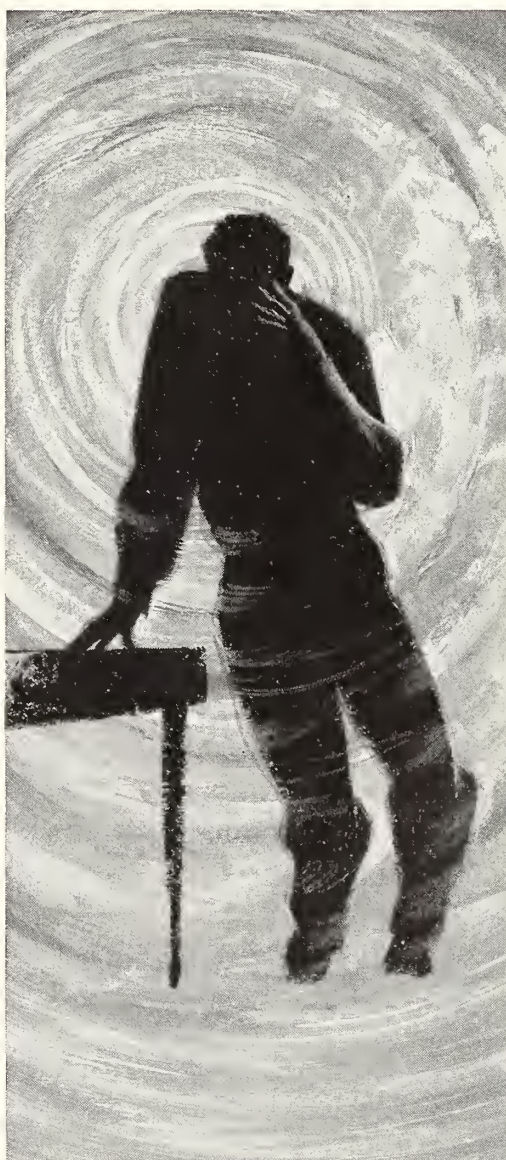
Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"\* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



*The site of Dramamine's action is probably in the labyrinthine structure.*

\*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP 8:35 (Nov.) 1953.

## WHY NOT ENCOURAGE THE SELF-EMPLOYED TO BUILD THEIR OWN RETIREMENT FUNDS?

EMPLOYED persons in the United States are at least partially protected for their old age by Social Security. In addition, many of them are the beneficiaries of company pension funds. Payments into such funds by employers, as well as employers' share of the Social Security tax, are deductible from taxable income. Up to now, however, there is no similar provision for a large group of self-employed people such as physicians, lawyers or farmers. Their efforts to provide for retirement are hampered by exorbitant taxation.

In the Philadelphia area recently, a physician enjoying a large and presumably profitable private practice retired and took a job in a Government hospital. He gave as his reason for doing so the fact that he had been unable to educate his children and at the same time save enough to provide for eventual retirement. He felt himself compelled to become an employed person in order to receive the benefits of a pension fund. A young doctor or lawyer, after a long and expensive education and apprenticeship, is likely to find adequate saving almost impossible under present conditions.

Congress is now considering a measure which is designed to fill some of these gaps. The Jenkins-Keogh bill, which was introduced last year, is an outgrowth of several efforts to solve the problem. In general, it provides that any individual who is not eligible to participate in a pension or profit-sharing plan may set aside each year an amount not to exceed 10 per cent of his earned income, and in no case more than 7500, to be paid into a restricted retirement trust or insurance annuity. The amount thus set aside could be deducted from his taxable income. The

proposed law places certain restrictions on the means by which the savings can be accumulated and provides that the taxpayer may not tap the fund until he is sixty-five years old, "except in the case of total disability." This would place him roughly on the same footing with employed individuals who are the beneficiaries of private pension funds.

Undoubtedly the proposed measure does give the self-employed certain other advantages over their opposite numbers in the ranks of the employed. For example, the beneficiary of some company pension funds may not accept a job in another company without forfeiting his equity in a pension from his first employer. The self-employed doctor who builds up his own retirement fund may leave his community and set up shop somewhere else and still hang on to his retirement allowance. There are undoubtedly other discrepancies, but if an individual can do better on his own account than through a company pension fund, this might be an important step away from the welfare state. Private saving should be made at least as attractive as reliance on contributions by employers or the Government.

Few reliable estimates have been made of the possible loss of revenue to the Government if such a law were passed. However, as a writer in the *Harvard Law Review* has observed, "even the possibility that the revenue loss would be so considerable as to necessitate higher tax rates is not a valid objection; it seems more equitable to distribute the tax burden among all taxpayers than to continue discrimination against one group."

—The Saturday Evening Post

# The President's Page

THE ANNUAL SESSION of the Indiana State Medical Association will convene at Indianapolis on October 24. The plan of having the first meeting of the House of Delegates on Sunday will be tried again this year. This adds another day to the meeting for the delegates, but it does away with the interference that has always existed when we tried to hold general meetings and reference committee meetings while the House was in session.

The Committee on Convention Arrangements has prepared a very good program both scientific and for your entertainment. You see—we have a bigger budget this year. Mr. Waggner has been able to sell a great deal more commercial exhibit space than ever before. We feel that the interest displayed in the exhibits at French Lick has helped bring in more exhibitors at the Indianapolis meeting. Then, too, we will have an automobile to give away as the grand prize at this meeting.

Our annual meetings have become so large it is hard to hold them anywhere but Indianapolis or French Lick. I am pleased at the increasing interest in the Indiana State Medical Association, as there is a real need for the organization in these troubled times. The real need is for more physicians to take an interest in organized medicine. It is true we have 250 physicians on the various committees and another hundred as delegates and officers, but this can only take a small part of the 4,000 members of the association. However, many of the others can be active in their local county and district societies. I feel that everyone in the profession should take some part in the organization.

The doctor is called upon to attend so many meetings that sometimes you get a little tired of meetings in general. Some counties have a joint staff and county meeting several times a year, which not only cuts down the number of meetings but also increases the attendance at the county meeting.

I was reading Kemper's Medical History of Indiana the other night and found that one of their complaints a hundred years ago was to get men to attend meetings. Their main difficulty was transportation, because the delegates to state conventions took four days on horseback to reach Indianapolis from southern Indiana. Incidentally, they elected the youngest men in the group, as they were more able to make the trip.

By the time this goes to press the National Congress will have adjourned. As it looks now, the medical profession came through without much damaging or harmful legislation. It would be a good idea to contact your legislators during the summer and tell them their work was appreciated. Your consideration will help in future relations not only between you and the lawmakers but also between them and the Washington office staff.

*Wm Harry Howard M.D.*



# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

One of the projects given the Auxiliary by our parent organization and by the American Medical Association is the sale of TODAY'S HEALTH magazine. Since this is such a splendid public relations medium for the medical profession, and since it contains only carefully sifted and authentic medical information, we are asking you doctors to help us.

The quota which has been set up for all county Auxiliaries is the number of its members. The same system is used for the state. We did very well last year. Kosciusko County Auxiliary, with Mrs. Ryland Roesch as chairman, won third prize in the nation for counties in her membership class, and received an award of \$15.00. She went over her quota by 1,089%! Eleven other Indiana counties went over their quotas and won National recognition. They were, in order of their standing, with their chairmen: Porter, Mrs. E. J. De Grazia; Perry, Mrs. N. L. Neifert; Lawrence, Mrs. T. J. Fountaine; Floyd, Mrs. Gerald Wahlfeld; Wayne-Union, Mrs. W. R. Stilwell; Randolph, Mrs. N. Rothermel and Mrs. D. Wagoner; Decatur, Mrs. Charles Overpeck; Rush, Mrs. B. D. Hoover; Boone, Mrs. Harvey Lovett, president; Elkhart, Mrs. Glenn B. Patrick; Vigo, Mrs. Richard J. Reynolds; St. Joseph, Mrs. Everett Donnelly; and Vanderburgh, Mrs. A. W. Ratcliffe. Our congratulations to all of them!

However, no state with a membership of over 2,000 made its quota last year. Indiana only reached 66% of its quota, in spite of the fact there are 2,448 auxiliary members, and 3,819 members in the Indiana State Medical Association! *Surely every M.D. in Indiana, who has an office, should have this magazine in his reception room!* To the profession, this magazine costs only a very small sum. Why not give it as a Christmas gift to your friends and relatives? It is a very welcome gift in any family with children! Give a subscription to your barber, the postman, and many others.

Last year in Vanderburgh County, (Mrs. A. W. Ratcliffe, chairman), the County Medical Society helped the Auxiliary place TODAY'S HEALTH in every barber and beauty shop in Evansville. One doctor in Kosciusko County gives 15 subscriptions each year!

We have made inquiry and find the Indiana State Medical Association has no chairman for this project, which is all the more reason why you should support your county Auxiliary's TODAY'S HEALTH chairman. Ask her for subscription prices. Presidents, please bring it up before your Medical Societies.

On July 23, at my home, we had a meeting of those TODAY'S HEALTH chairmen who won National recognition. There were many ideas advanced to help us reach our goal. When your Auxiliary asks for your support, I hope you will make it 100% at least. Some of our largest Auxiliaries are pledged to make every effort to reach their quotas. In doing so they will have the satisfaction of knowing they are providing authentic health information to lay people, as well as reaching the goal set for us by A. M. A. And, more important, they are performing a splendid public relations program for the medical profession.

Many of your patients, no doubt, ask you where dependable health information may be obtained; or you may have many opportunities to mention this magazine to them, especially those with children. Many health teachers use this magazine as a textbook, and there is a special price made for this. There is a reduction, both to the profession and to the public, for subscriptions for two or more years.

The Indiana State Medical Association has very kindly promised us the use of a table at the annual meeting in October, where we will be able to show you copies of TODAY'S HEALTH magazine, and give you any information about it. Should you subscribe for it here, your own county Auxiliary will be given credit for the subscription. We are counting on you. With your help we can reach our goal!

Grace Harvey, President

## WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.<sup>1</sup>

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."<sup>2</sup>

"Premarin" is a preparation of choice for the replacement of body estrogen. "Premarin" presents a *complete* equine estrogen-complex and all the components of this complex are meticulously preserved in their natural form. This largely explains why "Premarin" not only produces prompt symptomatic relief but also imparts an important "plus"—the distinctive "*sense of well-being*" that patients find so highly gratifying. These benefits of "Premarin" have made it a natural estrogen widely prescribed by physicians . . . and often preferred by patients.

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**... imparts no odor**

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estrogens (equine), available in both tablet and liquid form*

1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

NEW YORK, N. Y.



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No man is really happy or safe without a hobby, and it makes precious little difference what the outside interest may be—botany, beetles or butterflies, roses, tulips or irises; fishing, mountaineering or antiquities—anything will do so long as he straddles a hobby and rides it hard.  
—Sir William Osler, 1909.

## Inherited Christmas Train Makes Doctor a Confirmed Railroader

JOHN H. BARROW, M.D.

*Dale*

**M**Y ADVENT into model railroading was the same as hundreds of others—Christmas train to Son and inheritance when he tired of it. This took place in 1944 and I've been "walking the ties" ever since.

The first few pikes were more or less simple ovals done in "tin-plate" track. Soon this method of construction showed great limitations, mainly because ready-made track and rolling stock (tin-plate) does not lend itself to flexibility and realism of operation.

My hobby then began to engulf me. I wanted a pike that would do more than "merry-go-round."

An unused ping-pong table held a fair layout, with typical sidings, main lines, a couple of small villages, a few hills and cuts. The tinplate was replaced with individual road bed, ties, rails and ballast for realism.

Growing pains soon hit, and an addition carried an extension of the system. More towns, scenery and correlated paraphernalia were added. Still the simulated merry-go-round pattern existed and created a desire for more closeness to prototype.

My wife very graciously consented to my using all the wall space of the basement and

"Brass Hat" at control of "S" gauge pike pushing freight instead of pills.  
Partially completed portable "TT" gauge pike to be used for display at I.S.M.A. and other conventions.



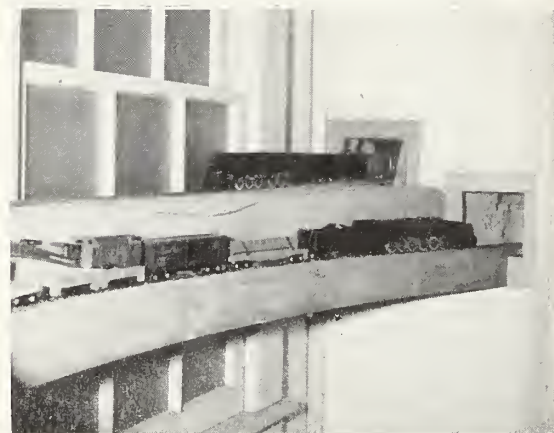
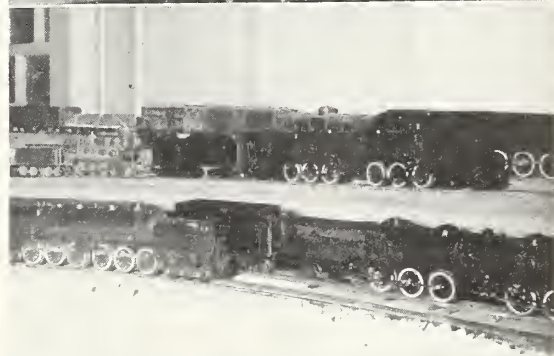


total new construction began in 1951. Bench work began and was fastened to the walls, being lower braced to form a non-floor supported shelf. Track work was planned for different levels and slowly constructed. Before any track was actually laid, the course of each line and siding was chalked out to scale. Bugs of direction were thus ironed out (I thought). Many slipped in, as I found out later.

To deaden sound, I used Celotex roadbed on top of plywood. Crossties were glued to this and the rails spiked to them. I cut the Celotex on my hand saw as well as the ties. Spikes and rail were purchased. Switches were "scratch" constructed, of the closed frog type; that is, they swing both frog and points about a center from closure rail (running rail) to closure rail. This type, though not prototype, is very conducive to non-derailing as well as being more quiet in running. Power to move the switches came from modified, war-surplus rotary relays with wafers stacked on them to carry power where needed.

I answered almost every ad concerning war-surplus material and, wherever possible, this low-priced, high-quality merchandise was used. Items of this nature lend themselves nobly to model railroad use with a minimum of conversion and rebuilding. Most all the electrical items are of the right voltage—O-18V, A.C. or D.C. However, this source of supply was limited and I kept my eyes open in auto parts bins, hardware stores, drug stores (plastic containers and display racks furnished much useful material), bathroom (tooth paste tubes for thin sheet metal) and, last but not least, my office. From there came all the old hemostats and needle holders of all sizes to furnish indispensable tools not found commercially.

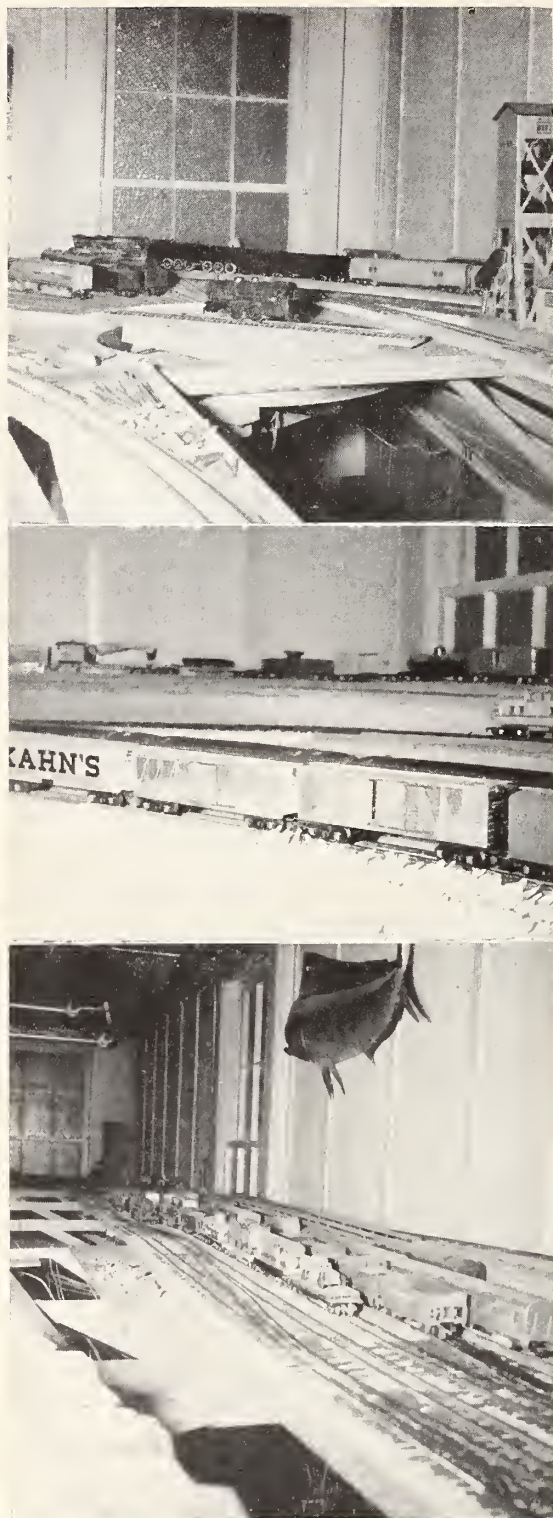
My rolling stock came from two sources. I purchased some from others who had started the hobby and were retiring from it, and from kids that had either outgrown, broken up, or tired of their Christmas presents. Some required a lot of work, some very little. However, I tried to rebuild all of it to match the other source—scratch-built. This source was the most interesting (and laborious), as one can go by prototype plans and copy the real McCoy and have items that really look "railroad." Decals and lithographed sides in true duplication of the authentic actually give miniature models.



- (1) "Scratch" built Ten Wheeler. Prototype was era's heaviest and fastest hauler. Circa 1865.
- (2) Articulated steam engines on right. Articulated turbine on left. The 1865 crept in the picture on the left center.
- (3) Knocked Knekle Tunnels. This is the concrete wall that took hours and skin.

In scratch-building, all cars and locomotives were fashioned from wood, brass, sheet metal, plastics, wire and tube walls from ointment and tooth paste containers. Only wheels and motors for engines, trucks and couples for cars, decals and a few lithographed sides, as mentioned, were bought.

Tools consisted, as I stated, of discarded medi-



- (1) Partially completed turntable and roundhouse. The turntable and coaling station are fully operating.
- (2) Freight revenue at yard throat allows lucrative diesel passenger entrance at center right.
- (3) Fish Yards. The dolphin oversees all operations and frowns on featherbedding and deadheading.

cal instruments, power tools in my basement work shop, such as drill press, band saw, cut-off saw, lathe, and the sundry hand tools found in any work shop.

Cars were models of all boxcars, flats, tankers, hoppers, gondolas, reefers, cabooses, mail, baggage, express, passenger, Pullman and observation cars, some streamlined and some standard. Trucks and couples were purchased, as they are very difficult to construct.

Locomotives, as I said, came from all sources—the original hand-me-down plus those I bought from parents whose children had discarded and from ex-hobbyists. Due to the length of my layout, I wanted larger engines to haul longer loads. The small, short engine couldn't meet these requirements. I amputated the front of one and the cab of another and presto! a transfusion and birth of a new, twice-as-powerful engine, articulated and champing at the bit. After approximately 100 hours on each job, 12 singles became 6 twins, and I had the long, sleek power plants I wanted.

A problem arose with the larger engines (one of the bugs I thought earlier I had licked), that of some of my curves of too short radii and switches too abruptly turning off main lines and yards. To rectify the line curves, I had to chisel two places through a concrete wall into the other side of the basement in order to ease four curves from 20-inch radii to 72 and 96 radii. Incidentally, this gave me about 20 feet more of track and 4 tunnels. In another corner of the basement, I had to tunnel through the corner of my bar cabinet and run one line on top of the bar and one on the wall behind it. All switches had to be torn out and easier turnouts installed. This called for extra electrical work as well.

One thing called for another, and I found that



I needed block control to prevent collisions. With the use of small magnets mounted one in a locomotive tender and one beneath the track attached to a contact switch, I had automatic block control by each individual train. At last! I can run two trains east and two west on double track and rest assured (?) that all will go well. (Just watch the "bugs" go to work when I have company and foul up the works!)

My landscaping has not progressed too far as yet. I have a few houses and buildings, but they require time and much labor to build. Anyhow, if I didn't have more to do, I'd feel that the project wasn't too interesting any more.

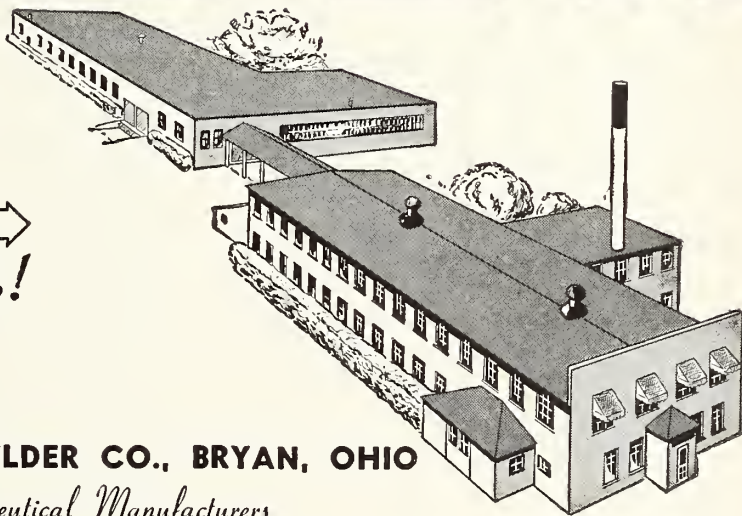
For diversion from the "S" gauge, I have taken out time to develop a "TT" layout. It is a three-level route, sceniced and portable. Construction on it followed the same general pattern of the "S" gauge. I might add the scale of the "S" is, 3/16 inch equals 1 foot, and the "TT" is, 1/10 inch equals 1 foot.

Most any time is open house, and I have had hundreds of kids from 4 to 80 in to see and "ooh!" and "ah!" Their eyes actually pop and very few fail to ask, "How and when did you do it?" My standard reply is, "From 9 to 1 or later—night time, that is." Much construction has taken place on my desk (glass covered) while practice was slow. Much time has been put in while waiting for that final OB call from the hospital. Rainy Sundays and holidays have contributed a share of hours. All totalled, I figure I have spent 3,000 hours in 10 years and am not done yet. However, I ask the question, is a hobby ever done?

I shall be more than glad to have anyone, already working in the hobby in any gauge, visit or write me concerning the hobby, so we can discuss our problems. I would be most interested in getting all of the doctors of the I.S.M.A. who are in the hobby together to form a sort of Model Railroad Society. In this way we could have a room at each convention where we could have various layouts exhibited and could "chew the fat." Model Railroading is work, but lots of fun. How about it, fellow craftsmen?

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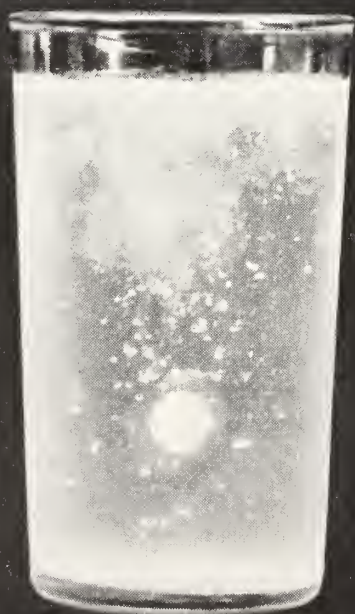
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# Scientific Program for ISMA Convention Lists Notable National, State Speakers

**T**HE 105th ANNUAL CONVENTION of the Indiana State Medical Association will convene in Indianapolis on October 24 when the Executive Committee, the Council, and the House of Delegates will meet in the Student Union Building, Indiana University Medical Center.

Registration starts at 8 o'clock Monday morning, October 25, in Murat Temple. The first day's program includes the annual golf tournament, trap shoot, Editorial Board meeting, luncheons of various organizations, the Instructional Courses, dinner for women physicians, the buffet supper and stag party for the doctors, Auxiliary dinner and evening entertainment for physicians and their guests.

All scientific and technical exhibits will open at 8:30 a.m. Monday.

Tuesday the traditional President's Night dinner is scheduled with Wm. Harry Howard, M.D., Hammond, delivering the address with a topflight entertainment program following.

The annual dinner and presentation of awards will be held on Wednesday evening in the Athenaeum.

Scientific program features follow in brief:

## Tuesday

- 9:35 a.m. "Medical and Surgical Emergencies"—a symposium  
Chairman: James O. Ritchey, M.D., Indianapolis  
Participants:  
"Surgical Emergencies"—R. Arnold Griswold, M.D., Professor of Surgery, University of Louisville  
"Pediatric Emergencies"—William C. Vance, M.D., Richmond  
"General Practice Emergencies"—George L. Thorpe, M.D., Wichita, Kansas  
"Medical Emergencies"—speaker not confirmed  
"Anesthesia Emergencies"—Paul H. Lorhan, M.D., Professor of Anesthesia, University of Kansas School of Medicine  
"Orthopedic Emergencies"—Joseph C. Lawrence, M.D., Evansville
- 11:00 a.m. **INDUSTRIAL MEDICAL PRACTICE**  
"The Role of the General Practitioner in Industrial Medicine"—G. F. Wilkens, M.D., Medical Director, New England Telephone and Telegraph Company, Boston, Mass.  
"Industrial Backs"—Fremont A. Chandler, M.D., Professor of Orthopedic Surgery, University of Illinois College of Medicine
- 2:00 p.m. "Newer Developments in Medicine"—panel discussion  
Moderator: Kenneth G. Kohlsteadt, M.D., Indianapolis  
Participants:  
"Evaluation of Pentothal Curare and Other New Anesthetics"—Dr. Lorhan  
"Use of Adjuvants in Vaccines"—Clyde G. Culbertson, M.D., Indianapolis  
"Surgery"—Dr. Griswold  
"The Use of Radioisotopes in the Treatment of Pelvic Malignancy"—Allen C. Barnes, M.D., Professor of Obstetrics and Gynecology, Western Reserve University, The School of Medicine, Cleveland  
"Technique of Radical Neck Dissection"—Bruce Proctor, M.D., Detroit  
"Modern Concepts of Lupus Erythematosus"—John A. Haserick, M.D., Cleveland  
"Evaluation of the Antibiotics"—William W. Frye, M.D., Dean and Professor of Tropical Medicine, Louisiana State University School of Medicine, New Orleans  
"Revascularization of the Myocardium for the Treatment of Coronary Artery Heart Disease"—Emanuel Marcus, M.D., Hammond  
"Newer Drugs in Hypertension"—speaker not confirmed

## Wednesday

- 10:30 a.m. "Fractures of the Ankle"—Carl L. Gillies, M.D., Professor of Radiology, State University of Iowa College of Medicine, Iowa City
- 11:00 a.m. **MEDICAL - ECONOMIC AND LEGAL MEDICINE**  
"The Government as a Business Competitor"—Joseph F. Leopold, Dallas, Texas  
"Report, State of Indiana Commission on Alcoholism"—Dean L. Barnhart, Indianapolis

## SECTION MEETINGS MEDICINE

- 2:00 p.m. "Spastic Colon Syndrome"—F. M. Thompson, M.D., Columbia City  
"Ophthalmology's Stake in Systemic Disease"—E. W. Dyar, M.D., Indianapolis  
"Experiences of an Isotope Committee"—Stephen L. Johnson, M.D., Evansville.  
"The Use and Abuse of Bone Marrow Biopsy"—Louis A. Schneider, M.D., Fort Wayne  
"Vectorcardiography"—Charles E. Jackson, M.D., Bluffton

(Continued on Page 1042)



# I. U. Medical Center Selected by 25 Physicians for Internships

**T**WENTY-FIVE PHYSICIANS who have selected the Indiana University hospitals for a year of postgraduate training before entering the practice of medicine, began their internships on the I. U. Medical Center campus July 1.

During their year of clinical training under the supervision of the Medical School faculty and hospital staffs, members of the intern staff will rotate between surgery, medicine, pediatrics, obstetrics, and the other fields of present-day medical practice.

Sixteen members of the new intern group are graduates of the Indiana University School of Medicine, including: Dr. John J. Bergen, 3114 East 34th st.; Dr. Charles M. Dill, 4130 Otterbein st.; Dr. Paul M. Eicher, 4251 Bowman st.; Dr. William C. Heihman, 3542 N. Emerson; Dr. Charles L. Miller, 5112 W. Ford; and Dr. William D. Ragan, 129 West 44th st., all of Indianapolis.

Other I. U. graduates serving internships at the University hospitals include: Dr. Joseph B. Butler, Crothersville; Dr. James R. Carpenter,

Princeton; Dr. Dallas B. Fouts, New Albany; Dr. L. Dale Olson, Gary; Dr. George S. Porter, Lebanon; Dr. Malcolm L. Rusk, Wallace; Dr. James J. Schaffer, Terre Haute; Dr. Edward C. Shipley, Crown Point; Dr. John H. Smith, and Dr. Michael L. Yacko, both of Mishawaka.

Graduates of other medical schools who will intern at the I. U. hospitals, here, are: Dr. William F. Bastnagel, Mt. Carmel, Ill., St. Louis University; Dr. John W. Burgess, Rock Island, Ill., University of Michigan; Dr. Versa Cole, Scotts, Mich., University of Chicago; Dr. Fred J. Fiederlein, Plainfield, N. J., Yale University; Dr. Thomas W. Howarth, Detroit, Mich., Hahnemann Medical College; Dr. Lee McHenry, Cincinnati, Ohio, University of Cincinnati; Dr. William B. Rabenn, Milwaukee, Wis., University of Wisconsin; Dr. James J. Vandenberg, Seattle, Wash., University of Washington; and Dr. Joseph J. Zore, 1406 N. Concord, Indianapolis, Marquette University.

Dr. Guthrie E. Carr, West Lafayette, a graduate of the I. U. School of Dentistry, is serving his internship in the University hospitals here.

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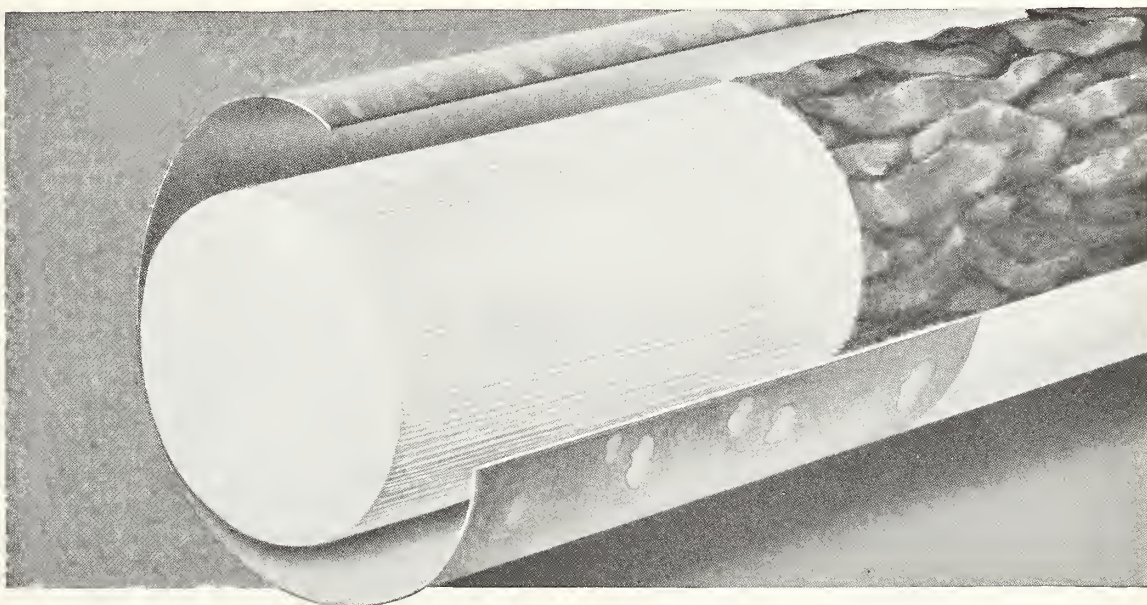


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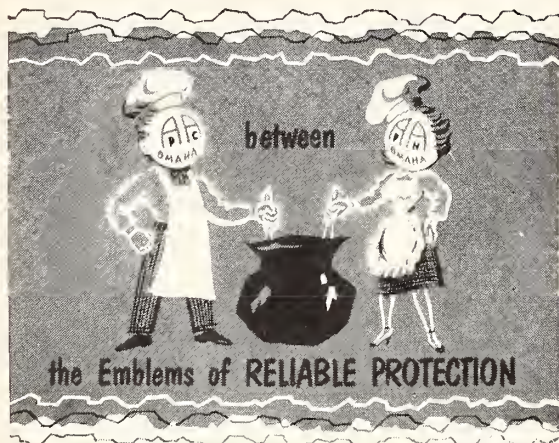
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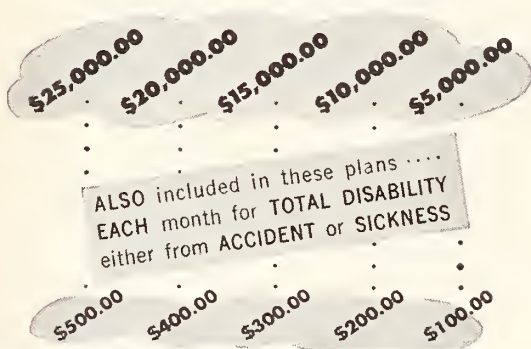
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3. Senior fellowships for more experienced investigators will carry an award of \$6,000 to \$7,500 per annum and are tenable for five years.

The deadline for applications is October 15, 1954. Applications will be reviewed and awards made in January 1955. For information and application forms address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, New York.

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## Indiana Licenses 36 Physicians During April, May and June

The following physicians have been licensed to practice in Indiana, according to a quarterly report made by the State Board of Medical Registration and Examination.

Names follow with the location listed for practice: Charles L. Warner, M.D., Evansville; William A. Blair, M.D., Indianapolis; Edward N. Hinko, M.D., Indianapolis; Thomas K. Roberts, M.D., Michigan City; Harold M. Manfredi, M.D., Chicago; Bennie L. Davis, M.D., Terre Haute; Arthur R. Radziewicz, M.D., Newburg; Joe Atlas, M.D., Indianapolis; Samuel Daughy, M.D., Indianapolis; Frank P. Lloyd, M.D., Indianapolis; David Rosenbaum, M.D., Indianapolis; Jackson Harris, M.D., Indianapolis; Ralph D. Bosch, M.D., Seymour; Philip C. Boyer, M.D., Indianapolis; Herbert Fleischl, M.D. (unknown); Robert F. Jeans, M.D. (unknown); Jack H. Oster, M.D., Westville; Erich Otten,

M.D., Indianapolis; James E. Southard, M.D., Indianapolis; Lester Cohn, M.D., Indiana Harbor; Herbert S. Jacobson, M.D., Indianapolis; Royce M. Brown, M.D., Indianapolis; Jerome Bresher, M.D., Richmond; George C. Chaney, M.D., Indianapolis; Kenneth Dirks, M.D., Indianapolis; John McKain, M.D., Indianapolis; Paul S. Rutherford, M.D., Evansville; Francis J. Arch, M.D., Indianapolis; Deward D. Peterson, M.D., Indianapolis; Robert S. Zullo, M.D., Michigan City; Harold Davidson, M.D., Evansville; Carl K. Schloss, M.D., Indianapolis; Hans W. Freymuth, M.D., Indianapolis; Carl A. Sardi, M.D., Indianapolis; William F. Hawn, M.D., Jeffersonville; Ladislav Wojcik, M.D., Marion.

Licenses were revoked for Maria Wasy, Gary, midwife; Flavia Doty, M.D., and Mabel Taulds, M.D., both of Gary.

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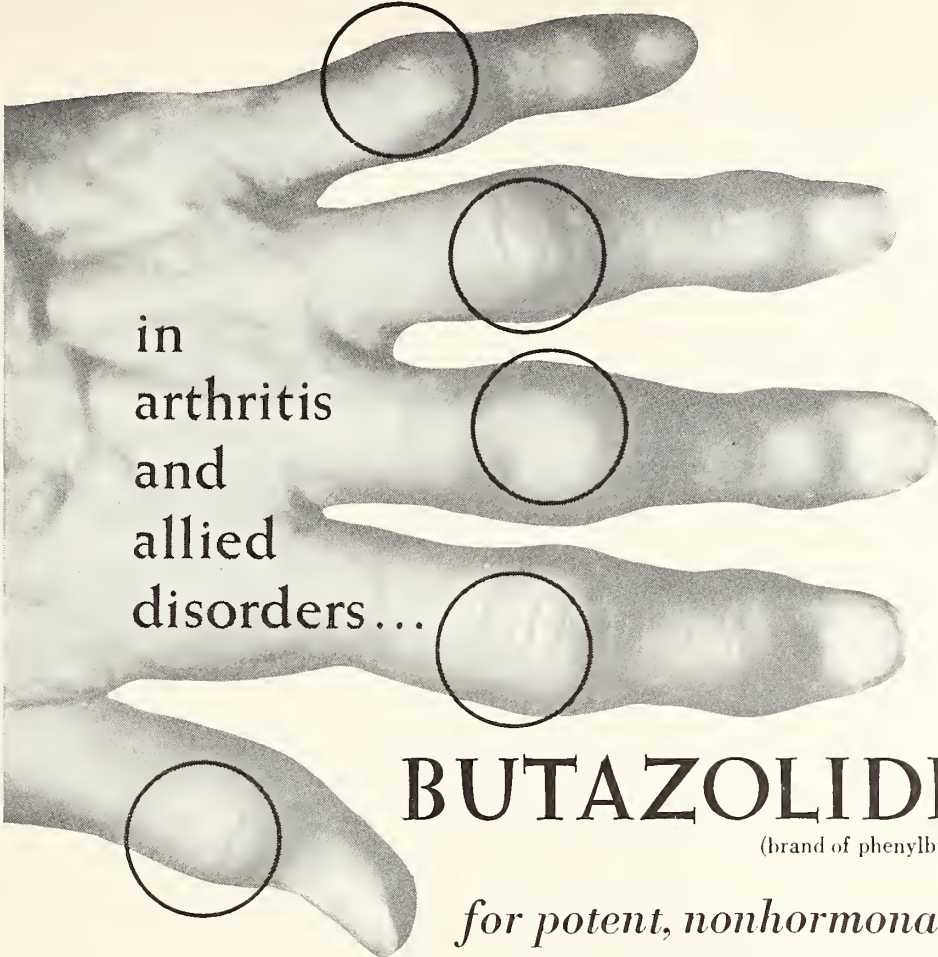
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\*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: *Geriatrics* 9:111 (Mar.) 1954.

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

## THE MONTH IN WASHINGTON

Washington, D. C. — While Congress didn't enact all the health bills President Eisenhower's administration wanted to put through, it did mark up an imposing record of accomplishment. In fact, it passed more health and medical legislation than any Congress in many, many years. The A.M.A. actively supported most of the bills finally enacted, and opposed none of them.

Four important new laws were written into the statutes before the session ended—expansion of the Hill-Burton hospital construction program, expansion of the vocational rehabilitation program, amendment of the income tax law to allow more liberal deductions for medical expenses, and transfer of the responsibility for health of the Indians to U. S. Public Health Service.

For years a group of state health officers have been working to bring about the transfer of Indian hospital and medical service from the Indian Bureau in the Department of the Interior to Public Health Service in what is now the Department of Health, Education, and Welfare. The health officers could show beyond any question that the Indians were receiving far less medical care than the rest of the population.

What might be called governmental inertia succeeded in holding up the legislation for a time, but this Congress decided to make a shift. Public Health Service, which will take over on the reservations next July 1, already has plans under way to insure the Indians more and better medical care.

The demands for a more dynamic vocational rehabilitation program have been building up outside the federal government as well as in Washington. The problem facing this administration was to get more people rehabilitated but at the same time to induce the states to take a more active part in the work. The law now enacted promises to do this. It authorizes grad-

ual increases in the federal appropriations, but at the same time is aimed at bringing the states up to the position of full financial partners by the end of five years. The goal is to rehabilitate at least 200,000 persons annually, in place of the present 60,000.

If local communities are willing to raise from one-third to one-half of the cost, the new Hill-Burton program should result in the construction, within three years, of possibly a half billion dollars in new facilities—rehabilitation centers, diagnostic-treatment clinics, chronic disease hospitals, and nursing homes. (This program was discussed in detail last month in this space.)

On the medical cost deduction question, too, economists long have felt that families with unusually large medical expenses should be given more liberal tax deductions. The new law will allow them to deduct medical expenses in excess of three percent of taxable income. Under the old law the figure was five percent. A \$3,000-income family with \$150 in medical expenses under the old law could deduct nothing, but under the new law \$60. The Treasury estimates that the total saving to families will be \$80 million.

The general public probably read and heard more about the one bill that was defeated—reinsurance—than it did about all the health and medical legislation that passed. That defeat (in the House) was a surprise and a disappointment to the President. His advisors might have told him that all was not well, but obviously they did not. Opposition was not confined to the A.M.A. Also lined up against it were most of the health insurance companies, the U. S. Chamber of Commerce and a number of other professional groups. The labor unions would accept it, but wouldn't work to get it. Most significant of all, it had lukewarm support at best from the lawmakers who know most about it, the Senate and House committees that conducted the hearings.



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# Deaths . . .

Louis L. Gilmore, M.D., 78, Knox county physician for 54 years, died in Good Samaritan Hospital, Vincennes, July 15, after an illness of two years.

Dr. Gilmore was a native of Monroe City, and established his practice there in 1899 after receiving his medical degree from Eclectic Medical College, Cincinnati. In 1930 he moved to Vincennes where he remained in practice until forced to retire by illness. He served as Knox county coroner for a number of years. Dr. Gilmore held membership in several branches of the Masonic order and had been honored with his 50 year membership pin. He was a senior and 50 Year Club member of the Knox County Medical Society and Indiana State Medical Association.

Herman C. Groman, M.D., retired Hammond physician, died July 22 of a heart attack

in his summer home at Whitehall, Michigan.

Dr. Groman was a native of Iowa, a graduate of Yale University and received his doctor of medicine degree from Rush Medical College in 1908. That year he established his practice in Hammond where he was actively associated with his profession and many civic undertakings until his retirement in 1939. He served as surgeon for the New York Central Railroad and specialized in industrial practice.

During his student years at Yale Dr. Groman participated in two Olympic games, winning the 440-yard dash in both events and setting a world record in 1904. He continued his athletic interests after establishing his Hammond practice.

An amateur student of anthropology and world affairs, Dr. Groman had made three trips around the world. In his travels he had made an unusual collection of lamps, in-

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cluding prehistoric devices. He had established a Groman Hand of Friendship Fund of the Adventurers Club of Chicago to further the study of natural history throughout the world.

Dr. Groman was a member of the Explorers Club of New York, the Masonic order, a past president of Hammond Kiwanis and held membership in Lake County Medical Society, the Indiana State, American and World Medical Associations.

He was a former city health officer and, although retired, served during World War II as medical examiner for both of Hammond's draft boards.

**Charles B. Gutelius, M.D.**, retired Indianapolis surgeon, died July 26 in Veterans' Hospital, Indianapolis. He was 76, and had entered the hospital for a physical examination.

A native of Bluffton, Dr. Gutelius was a graduate of the Indiana Medical College, Indianapolis, and had practiced in Indian-

apolis from 1906 until his retirement three years ago. For many years he was associated with Dr. David Ross who died in 1931.

Dr. Gutelius served in France with the Army Medical Corps during World War I and retired as a lieutenant-colonel. He held memberships in church, lodge and patriotic groups and had served as a district and national officer in his fraternity. He was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.

**Ernest M. Conrad, M.D.**, 84, Anderson, was killed in a two-car collision near Lapel July 31. He was accompanied by his wife who was hospitalized but not seriously injured.

Dr. Conrad was a graduate of the Medical College of Indiana at Indianapolis where he received his degree in 1897. In recent years he had limited his practice to pediatrics.

Dr. Conrad was a senior member of Madison County Medical Society and a Fifty Year Club member of Indiana State Medical

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Association. He had been active for many years in his medical society and during 1923-1924 served as Councilor of the Eighth Medical District.

John H. Rosenberg, M.D., 72, who had practiced medicine in Indianapolis for 50 years, died August 4 in his residence. He had been ill for four months.

Dr. Rosenberg was a native of Indianapolis and a graduate of the Eclectic Medical College of Indiana in 1904. For many years he

practiced on the South Side, specializing in obstetrics. He had delivered more than 5,000 babies. During the last eight years he had been in general practice.

Laurence E. Jewett, M.D., 81, who was a practicing physician in Wabash for many years, died August 7 in Excelsior Springs, Missouri, where he had been living.

Dr. Jewett was a native of Huntington county. He received his medical degree from the Indiana Medical College (Purdue) at Indianapolis in 1906. For a number of years he practiced with his father-in-law, Dr. T. R. Brady, at Wabash. He served as a major in the medical corps during World War I. Returning to Wabash, he became the first commander of the American Legion post. In 1949, Dr. Jewett established his home in Indianapolis with his son, Dr. Robert E. Jewett. He went to Excelsior Springs in 1952. Dr. Jewett was a senior member of Wabash County Medical Society, the Indiana State Medical Association and American Medical Association.

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# NEWS NOTES—from State and Nation

## PG Courses on Diseases of the Chest Scheduled for Fall

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the state chapters and staffs of local hospitals, will sponsor the Ninth Annual Postgraduate Course on Diseases of the Chest at the Hotel Knickerbocker, Chicago, and the Seventh Annual PG Course at the Hotel New Yorker, New York City. The Chicago meeting will be October 18-22; the New York meeting November 8-12.

Additional information may be secured from the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

The Fourth Annual Scientific Assembly of the **Ohio Academy of General Practice** will

be held September 22 and 23, 1954, in the Deshler-Hilton Hotel, Columbus, Ohio. Further details may be obtained from Dr. Earl D. McAllister, Executive Secretary-Treasurer, Rooms 407-410, 209 South High Street, Columbus 15, Ohio.

**Dr. Carl P. Huber**, Indianapolis, will address the annual session of the Michigan State Medical Society, September 30, on the subject "Abruptio Placentae." The session will be held in the Sheraton-Cadillac Hotel, Detroit.

**Dr. Robert L. Parr**, 1947 graduate of I. U. School of Medicine, has opened an office for the practice of pediatrics at 3740 Central Avenue, Indianapolis, where he is associated with Dr. William M. Browning. Dr. Parr has served with the U. S. Public Health Serv-

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ice and done virus research at Yale University School of Medicine during the last two and one-half years.

**Dr. Donald M. Hickman**, who has just completed a tour of duty with the U. S. Air Force, has opened an office for the general practice of medicine and surgery at 1832 South Calhoun Street, Fort Wayne. He is a native Iowan, received his medical degree from Creighton University at Omaha in 1949, and interned at Mercy Hospital, Des Moines, Iowa. Dr. and Mrs. Hickman and their four children are residing at 1408 North Anthony Boulevard.

**Dr. L. John Vogel**, who has served as a captain in the U.S. Army for the last two years, has returned to Mt. Vernon to resume his practice.

**Dr. Tom Brown**, former Delphi physician, was recently awarded the Violet H. Keller award at Herman General Hospital, Houston, Texas. The honor is given to the out-

standing resident each year at the hospital and covers a month's study with expenses paid at any hospital in the United States. Dr. Brown is specializing in radiology.

**Dr. Hymen Cohen**, graduate of the University of Illinois School of Medicine, has established an office in Hebron after completing his internship at Gary Methodist Hospital. He is occupying former offices of Dr. H. C. Ashmore, who has moved his practice to Chesterton. Dr. Cohen's wife, Dr. Ellen Cohen, also a graduate of Illinois, will complete her internship at Gary Methodist September 1.

**Dr. Allen Wayne Aldred** began the practice of medicine in Rising Sun July 9. He is occupying former offices of Dr. Charles N. Manley, who is now in Cincinnati. Dr. Aldred is a native of Switzerland county and a graduate of I. U. School of Medicine. Mrs. Aldred is a registered nurse and also a Switzerland county native. They have two children.

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### Dr. John Whitehead Honored by Hospital

Dr. John Whitehead, who served as chief anesthetist at Methodist Hospital, Indianapolis, for many years, was honored June 15 when a bronze plaque bearing his likeness was presented to the hospital by the medical staff. The presentation was made at the quarterly staff meeting by Dr. Roy A. Geider, Indianapolis. Dr. Whitehead was unable to attend, due to illness; however, members of his family were present for the ceremony.

Dr. R. Louis Curry, native of Greentown, has opened an office for the general practice of medicine in Columbus at 409 Tenth Street. He is a graduate of Hahnemann Medical College, Philadelphia. Dr. and Mrs. Curry and their three sons are living in the Columbus Village apartments.

Dr. John T. Burns, who completed a two-year residency at Riley Hospital, Indianapolis,

June 30, has opened an office at 5 North 25th Street, Lafayette, where he will specialize in pediatrics. Dr. and Mrs. Burns have moved to 1115 King Street, Lafayette.

Dr. John E. Krueger is associated with Dr. Raymond J. Berghoff in the practice of general medicine and surgery at 306 East Jefferson Street, Fort Wayne. Dr. Krueger is a native of Moline, Illinois, a graduate of the State University of Iowa College of Medicine, and interned at St. Joseph's Hospital. He is a Marine Corps veteran of World War II. His residence is at 2424 North Anthony Boulevard.

Indianapolis doctors recently entering service, all in the United States Navy, include Drs. Robert Kopecky, Abe H. Leff, Morris Salzman, Edward P. Thomas and Joseph H. Tuchman.

Dr. John T. Ferguson will leave the staff of Logansport State Hospital September 1



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to complete his residency in psychiatry at Traverse City State Hospital, Traverse City, Michigan. Dr. Ferguson is a 1948 graduate of Indiana University School of Medicine and served his internship at the I. U. Medical Center.

**Dr. Richard D. Hawkins**, native of Bedford, has returned to that city, where he will specialize in pediatrics. He opened offices in July at 1021 Fifteenth street in the Indiana Theatre building. Dr. Hawkins is a 1946 graduate of Washington University School of Medicine, St. Louis, served internship and residency at St. Louis Children's Hospital and then spent two years in the U. S. Air Force. From 1949 to 1951 he was clinical instructor of pediatrics at Baylor University College of Medicine and practiced part time at Wharton, Texas. He had been at the Children's Clinic, Biloxi, Mississippi, from 1951 until he returned to Bedford.

### **I. U. Infirmary Adds Two Doctors to Staff on Campus**

Dr. Wilfred M. Lundblad and Dr. John M. Miller have been added to the staff of the Indiana University Student Health Service, according to an announcement by Dr. E. B. Quarles, director.

Dr. Lundblad is a graduate of the University of Minnesota and interned at Wesley Memorial Hospital, Chicago. He has recently completed a residency in internal medicine at Wayne County General Hospital, Eloise, Michigan.

Dr. Miller is a 1953 graduate of the University of Iowa and has completed his internship at Sparrow Hospital, Lansing, Michigan.

**Dr. Kermit Q. Hibner**, Indianapolis, has taken over the practice and offices of Dr. Paul W. Elliott at Danville. Dr. Elliott is serving a residency at I. U. Medical Center.

Dr. Hibner is a graduate of I. U. School of Medicine, and served his internship at Good Samaritan Hospital, Phoenix, Arizona.

**Dr. Mattie L. Young** has joined the staff of residents in psychiatric training at Norways Foundation Hospital, Indianapolis. Dr. Young is a graduate of the Medical College of Virginia and completed her internship at Mercy Hospital, Springfield, Ohio before joining the Norways staff early in July.

**Dr. Robert C. Keyes**, formerly of Peru, opened an office in Fort Wayne July 16 for the practice of pediatrics. He is a graduate of Indiana University School of Medicine, interned at Indianapolis General Hospital, and took special pediatric training at James Whitcomb Riley Children's Hospital. Dr. Keyes served as an ensign in the Navy during World War II. His office is at 111 Esmond street.

**Dr. Frank M. Lynn**, who has been a practicing physician in Peru since 1908, has moved his office from the second story of the Blue Drug Store building, where he had been for 40 years, to his home at 258 West Main street. He plans to continue his practice.



## **HANGER'S Suction Socket Prostheses**

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a short-acting  
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**Dr. John W. Rousseau** is now associated with Dr. Karl M. Beierlein in the practice of obstetrics and gynecology at 334 Medical Center Building, Fort Wayne. Dr. Rousseau is a native of that city, received his medical degree from the University of Michigan School of Medicine, and interned at Ohio State University Hospitals, where he also served his residency. From 1951 until 1953, Dr. Rousseau served as a captain in the Air Force Medical Corps.

**Dr. A. J. Krsek**, who recently completed his internship in Gary, is now associated with Dr. John J. Reed in Hobart. Dr. Krsek is a graduate of Indiana University School of Medicine. Dr. and Mrs. Krsek and daughter are residing at 331 North Linda street.

**Dr. Robert McIlwain** and **Dr. Eleanor McIlwain** announced their retirement from practice in Marion July 1. They have made no definite plans for the future. Dr. McIlwain,

a native of Grant county, has practiced in Marion since 1926. His wife, Dr. Eleanor McIlwain, was in general practice until 1935. Since that time she has been an oculist.

**Dr. Carl M. Ebersole**, who has been in practice in Walkerton for the last year, and **Dr. Paul S. Bourne**, who interned last year at St. Joseph's Hospital, Phoenix, Arizona, have taken over the offices and equipment of **Dr. George Nassef** in Walkerton. Dr. Nassef left for service in the U. S. Navy August 1. Dr. Bourne was graduated from Indiana University School of Medicine in 1953. He is a native of Nappanee, is married and has a young daughter. They will move to Walkerton soon.

**Dr. Robert F. Walter** has opened an office for the general practice of medicine at 1002 Waggoner avenue, Evansville. He is a native of that city, a 1953 graduate of I. U. School of Medicine, and interned last year at Gary Methodist Hospital. He served four years with the U. S. Army in the Philippines and Japan during World War II. Dr. and Mrs. Walter and son live at 1757 South Morton avenue.

Association of **Dr. E. Wade Adams** with **Dr. John R. Weber** for the practice of pediatrics, with offices at 710 West Wayne street, Fort Wayne, has been announced. Dr. Adams is a native of Hammond, received his M.D. from Indiana University School of Medicine, and is a Navy veteran, having served in the Far East during the Korean War.

**Dr. Robert P. Ulrey**, who recently completed his internship at St. Vincent's Hospital, Indianapolis, began the practice of medicine July 23 in the office of Dr. Marion C. Drake, 1201 Main Street, Elwood. Dr. Drake is stationed in Texas with the Air Force. Dr. Ulrey is a native of Seymour, and a graduate of Indiana University School of Medicine. He is a World War II veteran. He entered medical school after serving 38 months in the U. S. and Europe. Dr. and Mrs. Ulrey and their son are living at 826½ North Anderson street.

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### Fellowships for Teachers Offered by Polio Foundation

To increase the number of well-trained teachers in the field of preventive medicine, the National Foundation for Infantile Paralysis is now offering a limited number of senior fellowships to physicians interested in study and research in the teaching of preventive medicine. This is a new effort to bring support to this field.

The program of study may be undertaken at an approved school of public health or in a department of preventive medicine at an approved medical school.

The fellowships will be awarded to graduate physicians who are United States citizens or applicants for citizenship, have completed at least one year's internship in an approved hospital, and who have had not less than two years of additional training and experience. Awards are made for one or more years, with stipends ranging from \$4,500 to \$7,000 a year. Applications are accepted at any time during

the year. For further information write the National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, New York.

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Dr. John R. Crist has established an office for the general practice of medicine in Mt. Vernon at 114 West Second street. He formerly resided in Marion, but went to Mt. Vernon from Dayton, Ohio, where he interned at St. Elizabeth Hospital. He is a graduate of I. U. School of Medicine. Mrs. Crist, a physical therapist, will serve as his office assistant. They are residing at 204 West Fifth street.

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Dr. Reginald A. Bruce, who served as medical director of Muscatatuck State School, Butlerville, for the last year, has opened an office for general practice at 820 West Michigan Street, Indianapolis. Dr. Bruce is a graduate of I. U. School of Medicine and interned at Milwaukee County General Hospital.

## THE RETREAT

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**Dr. Dempsey Strange**, who has served as chief of the resident surgical staff at the VA hospital, Indianapolis, for the last two years, is now associated with Drs. Frank B. Ramsey and Jack E. Pilcher, 201 Hume Mansur Building. Dr. Strange is a graduate of the University of Chicago School of Medicine and served his residency at Indiana University Medical Center. He is a native of Starksville, Mississippi and was in private practice there for one and a half years.

**Dr. Richard R. Eggers**, native of Hammond, is associated with Dr. Fred N. Daugherty, 120 West Pike Street, Crawfordsville, where he will practice general medicine and surgery. Dr. Eggers is a graduate of Northwestern University Medical School and served his internship at Methodist Hospital, Indianapolis. Dr. and Mrs. Eggers and their two daughters are living at 411 South Walnut Street, Crawfordsville.

**Dr. John Haley**, 1953 graduate of Indiana University School of Medicine, is now asso-

ciated with Drs. Doster Buckner and George Buckner at 533 West Washington Boulevard, Fort Wayne. He will practice general medicine and surgery. Dr. Haley is a native of Fort Wayne and served his internship at Lutheran Hospital in that city.

**Dr. Glenn H. Speckman** has opened an office for the general practice of medicine at 2120 East 10th Street, Indianapolis. He received his medical degree from I. U. School of Medicine and recently completed his internship at Methodist Hospital, Indianapolis. Dr. and Mrs. Speckman and their son live at 5242 Park Avenue.

**Dr. Stanley Seipel**, native of Harrison County, has returned to that community to practice medicine after completing a one year residency in internal medicine at the Louisville Veterans' Administration Hospital. He is establishing his office in Lanesville. Dr. Seipel served 34 months in the U. S. Navy during World War II and on his return entered Indiana University. He received his



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T. J. Smith, M.D., Associate

degree in medicine in 1952 and then served his internship in Louisville General Hospital. Dr. and Mrs. Seipel will live in Lanesville.

Dr. John Hildebrand, 1952 graduate of Indiana University School of Medicine, has opened an office in his home at 1307 East Ewing Avenue, South Bend, where he will practice general medicine and surgery.

Dr. Roland W. Chamblee, who recently completed his internship at St. Joseph Hospital, South Bend, has opened an office for the general practice of medicine at 1018 West Washington Avenue in that city. He is a former resident of Chicago and received his medical degree from Meharry Medical College, Nashville, Tennessee.

Dr. Oscar Green, who was recently discharged from the U. S. Army Medical Corps after serving at Camp Atterbury, Walter

Reed Hospital, Washington, D. C., and in Korea, has opened offices at 3120 North Meridian street. He will specialize in ophthalmology and otolaryngology. Dr. Green was graduated in 1947 from I. U. School of Medicine and served his internship and residency at the I. U. Hospitals.

#### Moore Heart Clinic Offers Electrocardiography Course

The staff of the Robert M. Moore Heart Clinic of the Indianapolis General Hospital will give a course in electrocardiography which will be open to all physicians in Indiana.

The course will begin October 7 at 7 p.m. in the Lilly Auditorium at Indianapolis General Hospital. Lectures will last for one and a half hours and will cover all phases of electrocardiography.

Further information may be obtained by writing the Robert M. Moore Heart Clinic, Indianapolis General Hospital, Indianapolis 7, Indiana.

#### SCIENTIFIC PROGRAM FOR ISMA CONVENTION (Continued)

##### SURGERY

##### 2:00 p.m. SURGERY OF INFANTS AND CHILDREN

"The Orthopedic Aspect with Special Reference to Open Reduction of Certain Fractures"—N. F. Richard, M.D., Shelbyville

"Inguinal Hernia"—Pierre C. Talbert, M.D., Bluffton

"Congenital Hypertrophic Pyloric Stenosis"—C. M. Schauwecker, M.D., Greencastle

"Appendicitis in Infancy and Childhood"—Richard M. Davis, M.D., Marion

"Management of Congenital Obstructions of the Small Intestine"—Richard R. Hughes, M.D., Lafayette

"Surgical Treatment of Thoracic Lesions in Children"—J. S. Battersby, M.D., Indianapolis

##### OPHTHALMOLOGY and OTOLARYNGOLOGY

##### 2:00 p.m. "Eye Manifestations of Intercranial Aneurysms"—Mortimer Mann, M.D., Indianapolis

"Esophageal Obstruction and Swallowing Difficulties"—Herbert A. Lautz, M.D., Hammond

"Corneal Transplants and Wound Healing"—Marvin Cuthbert, M.D., Indianapolis

"The Surgical Anatomy of the Neck"—Dr. Proctor

##### GENERAL PRACTICE

##### 2:00 p.m. "Modern Office Therapeutics"—Dr. Thorpe

"The Problems Facing Family Physicians Today"—John S. DeTar, M.D., Milan, Michigan

##### OBSTETRICS and GYNECOLOGY

##### 12:00 Noon Moderator, Dr. Barnes

"Hypotensive Drugs in the Toxemias of Pregnancy"—Floyd T. Romberger, M.D., and Dr. Kohlstaedt, Indianapolis

"Obstetrical Anesthesia"—Carrol W. Hasewinkel, M.D., and Murwyn L. Hicks, M.D., Indianapolis

"Leukorrhea and Pruritis Vulvae"—Paul F. Muller, M.D., Indianapolis, and L. Howard Allen, Bedford

##### PREVENTIVE MEDICINE and PUBLIC HEALTH

##### 2:00 p.m. "Antibiotics and Changes in Intestinal Flora"—Dr. Frye

"The Health Officer Looks at the Polio Vaccine Field Trial"—a symposium

Moderator: Minor Miller, M.D., Evansville



# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

July 24, 1954.

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Wm. Harry Howard, M.D.; Walter L. Portteus, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump and Robert Hollowell, attorneys; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

### Membership Report

Number of members July 23, 1954	-----	3,817*
Number of members July 23, 1953	-----	3,723
Gain over last year	-----	94
Number of members December 31, 1953	---	3,822

\* Includes

- 128 in military service (gratis)
- 106 \$10.00 members (residents and interns)
- 265 senior members
- 63 members, dues remitted by Council
- 2 honorary members

AMA dues paid: 1952---3,569; 1953---3,628\*\*;  
1954---3,573.

\*\* Includes 420 members permanently exempted in 1952.

Statements of Receipts and Expenditures for May and June for the Association and *THE JOURNAL* were accepted by consent.

### Headquarters Office

Dr. Howard and Dr. Portteus reported on the successful operation of the headquarters room at the American Medical Association meeting at San Francisco, and it was their recommendation that this is something that should be continued.

The secretary reported on the employment of Mrs. Janet Lee in the headquarters office.

The secretary reported that he had been elected secretary-treasurer of the Conference of Presidents and had been requested to accept a three-year appointment to the A.M.A. PR Advisory Committee. By consent he was authorized to accept these offices.

### Treasurer's Office

Dr. Myers, treasurer, reported that the three U. S. Treasury Certificates of Indebtedness, for \$10,000.00 each, purchased June 1, 1953, had ma-

tured June 1, 1954, and this \$30,000 had been re-invested in U. S. Savings Bonds, Series K.

### Legislative Matters

#### National

The secretary reported on the activity on HR 7700, SB 3114 and HR 8356. Upon motion of Drs. Howard and Clauser the action was approved and it was recommended that in the future immediate action be taken whenever recommended by the A.M.A. Legislative Committee.

Dr. Portteus discussed the fact that he felt the communication system within the organization should be strengthened for the purpose of getting wires from the grass roots of medicine to Congress. He felt that some action should be taken whereby a councilor or some other individual should be responsible for the automatic wiring of Congressmen upon request of the headquarters office. This matter was discussed, no definite action being taken, it being referred to the Council for discussion.

#### Local

The secretary reported representatives of the Association had appeared before the Democratic and Republican Platform Advisory Committees and recommendation was made for planks in the party platforms.

### Annual Convention, Indianapolis

October 24, 25, 26 and 27, 1954

By consent it was agreed that the Executive Committee, Council and House of Delegates meetings on Sunday, October 24, should be held in the Student Union Building of the Indiana University School of Medicine.

By consent it was agreed that the banquet on Wednesday, October 27, should be held at the Athenaeum. The secretary was instructed to attempt to procure Elmer Hess, M.D., president-elect of the A.M.A., as the speaker for this program.

The secretary reviewed for the chairman of the Committee on Convention Arrangements the proposed entertainment program, which was accepted by consent.

The secretary was authorized to invite the presidents and executive secretaries of the adjoining states to be the guests of the association at the 1954 convention.

Banquet and stag party guest lists were approved by consent. Dr. Ramsey is to be asked to supply the names of military personnel who should be invited.

### Organization Matters

Letter from Mrs. H. C. Harvey, president of the Woman's Auxiliary, asking the advice of the com-



mittee in setting up a committee to work with Blue Cross and Blue Shield was read and the secretary was instructed to write the Blue Shield Executive Committee to determine what the intent and purpose of this committee was to be before giving Mrs. Harvey a reply.

The secretary reported that Dean VanNuys of the Medical School had called, reporting that a check from the American Medical Education Foundation in the amount of \$49,300.00 plus had been received by the school.

The secretary reported on the request of the committee to investigate the cost of renting exhibit space at the Union Station, Indianapolis, for use by the medical profession, medical school, and the hospitals. The secretary stated in contacting officials it was learned that a space 3 feet deep by 3 feet wide by 5½ feet high rents for \$490.00 per year.

Following discussion of this by Dr. Denny and others, upon motion of Drs. Clauser and Porteus the plan was approved and the secretary is to ask the Public Relations Committee to work out the details.

The secretary reported that the resolution proposed by the Executive Committee to be presented at the A.M.A. House of Delegates, asking for an investigation of the possibility of the A.M.A. recording scientific presentations made during the annual interim sessions, had passed the House and the committee is to make a report at the December meeting.

In discussing the activity of the recording library, upon motion of Dr. Howard, adopted by consent, the secretary was asked to write a letter to all department heads and the dean of the medical school, seeking permission to record various lectures given at the school for use in the loan library.

Letter read from Dr. George M. Cook, Hammond, chairman of the Committee on Heart Disease, stating the committee had approved the proposal of the Indiana Heart Foundation to establish a Cardiac-in-Industry program. Upon motion of Drs. Clauser and Myers, the Association concurred in the recommendation of the special committee and the secretary is to so inform the Indiana Heart Foundation.

A letter from the Health Education Consultant, southeastern branch of the State Board of Health, proposing that a regional conference be held on rabies, was read and by consent was referred to the Committee on Rural Health.

The secretary reviewed the reorganization of the Indiana Council on Children and Youth and read the points covered in the proclamation issued by the Governor of Indiana setting forth the purposes of the Council. This was approved by consent.

The secretary read a letter from Dr. J. F. Lewis, Liberty, Indiana, and excerpts of the reply made by Mr. Stump, as a matter of information.

Letter from Dr. Kenneth Kohlstaedt relative to

a plan being sponsored by the Kentucky Heart Association on heart surgery was referred to the Committee on Heart Disease by consent.

As a matter of information, the secretary called the attention of the committee to a letter which had been sent to the members by the Jefferson National Life Insurance Company regarding a new accident indemnity policy.

The secretary reported on the item carried by the Public Relations Committee in the recent News Flash concerning a proposed amendment to the Constitution and the misunderstanding that had developed in some circles relative to this item. On motion of Drs. Clauser and Myers it was suggested that the Legislative Committee make a thorough study of this proposed amendment and report back to the committee with recommendation as to what position, if any, the Association should take in this matter.

As a matter of information, the resolution received at the headquarters office from the Third District Medical Society was read to the committee, as was a resolution being proposed by Dr. Lester D. Bibler.

### The Journal

*Report on advertising* was accepted by consent:

Total, July, 1953 .....	\$3,272.20
Total, July, 1954 .....	3,747.60

Total, August, 1953 .....	\$2,404.06
Total, August, 1954 .....	2,471.59

Total, first six months, 1953 ..	\$12,359.74
Total, first six months, 1954 ..	17,727.85

*Election of Board members.* Dr. Ramsey called attention to the fact that election of board members at the fall meeting of the Council makes it impossible to notify the new members in time to attend the Editorial Board meeting which usually is held the following day. He recommended that the Council elect board members at the summer meeting in order that they may attend the fall meeting of the board, and he further recommended that the board meet at the same time of the Council spring meeting for the purpose of discussing editorial policies. By consent, the Executive Committee agreed to recommend this procedure to the Council.

### Medical Defense

The secretary was instructed to check with the Insurance Commissioner to determine if reduced rates by all malpractice carriers had been placed into effect in the state of Indiana.

### New Business

The secretary read a portion of the minutes of May 23 meeting of the Committee on Crippled

Children Services, which reported favorably on the matter referred to the committee by the Executive Committee for the establishment of a domiciliary facility for crippled children at Indiana University at Bloomington.

A letter was read, calling attention to the fact that the July issue of the monthly bulletin of the Indiana State Board of Health, would be the final issue, it being discontinued by the present administration. Upon motion of Drs. Portteus and Clauser the secretary was instructed to write a letter to Dr. L. E. Burney, secretary of the State Board of Health, recognizing the vast usefulness of the publication and stating that he hoped some method for continuing the publication might be found.

#### Future Meetings

American Public Health Association, Buffalo, October 11-15, 1954.

American Medical Association, interim session, Miami, November 28 to December 5, 1954.

Public Relations Institute, Chicago, September 1 and 2, 1954. Upon motion of Drs. Portteus and Myers the secretary was instructed to take both field secretaries to this meeting.

There being no further business the committee adjourned to meet again at 11:30 a. m., Sunday, August 22, 1954, at the Student Union Building, Indiana University Medical School campus.

### INDIANA STATE MEDICAL ASSOCIATION

#### The Council

July 25, 1954.

The Council of the Indiana State Medical Association convened for its summer meeting at 10:15 a.m., daylight saving time, Sunday, July 25, 1954, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Elton R. Clarke, chairman, presiding.

Roll call showed the following present:

#### Councilors:

First District-----Minor Miller, Evansville  
Second District-----Sam I. Rotman, Jasonville, alternate  
Third District-----William H. Garner, New Albany  
Fourth District-----J. E. Dudding, Hope

Fifth District-----Not represented  
Sixth District-----W. U. Kennedy, New Castle  
Harry P. Ross, Richmond, alternate  
Seventh District-----Lester D. Bibler, Indianapolis  
Don E. Wood, Indianapolis, alternate  
Eighth District-----T. R. Hayes, Muncie  
Guy A. Owsley, Hartford City, councilor-elect  
Ninth District-----Wemple Dodds, Crawfordsville  
H. E. Klepinger, Lafayette, alternate  
Tenth District-----James P. Vye, Gary, alternate  
Eleventh District-----Elton R. Clarke, Kokomo  
Twelfth District-----Maurice Glock, Fort Wayne  
Thirteenth District-----G. O. Larson, LaPorte, alternate

#### Officers:

Wm. Harry Howard, Hammond, president  
Walter L. Portteus, Franklin, president-elect  
Roy V. Myers, Indianapolis, treasurer  
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL  
James A. Waggener, executive secretary

#### Executive Committee:

James W. Denny, Indianapolis, chairman  
E. H. Clauser, Muncie, member

#### Guests:

Cleon A. Nafe, Indianapolis, A.M.A. delegate  
John D. VanNuys, Indianapolis, dean Indiana University School of Medicine  
L. E. Burney, Indianapolis, state health commissioner  
C. E. Gillespie, Seymour, past president, Indiana State Medical Association  
Albert Stump, Indianapolis, attorney  
Robert Hollowell, Indianapolis, attorney  
Robert J. Amick, field secretary  
Kenneth W. Bush, field secretary

Minutes of the meeting held at Indianapolis April 25, 1954, were approved as printed in the June, 1954, JOURNAL, on motion of Drs. Bibler and Portteus.

#### Reports of Councilors

Dr. Bibler extended a cordial invitation to members of the Council and the Executive Committee to attend the Seventh District Medical Society meeting, which is to be held at the Indianapolis Athletic Club on September 25. This will be a dinner-dance, sponsored by J. B. Roerig and Company of Chicago.

Doctor Hayes announced that Dr. Guy A. Owsley

## CLEARVIEW

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Albert J. Crevello, M.D., Medical Director



of Hartford City had been elected councilor of the Eighth District for the next three years.

### Reports of Officers

The president and treasurer had no reports at this time.

*Dr. Walter L. Portteus*, president-elect, reported that the Executive Committee had discussed the setting up of some plan "whereby we can improve our telegraphic services to Congress . . . a plan whereby each councilor would be responsible for four, five or six telegrams from his district . . . the idea being to institute some mechanism for sending telegrams to Washington from all over the state on very short notice. Sometimes we have only one hour's notice to send out telegrams. I think all of us will agree that messages from individual physicians have much more effect than telegrams from the state office. We must work out some way whereby this can be facilitated. Unless we have some mechanism of that sort, I think we are weakening our position and it is not as effective as it might be."

On motion of Drs. Miller and Garner, the Legislative Committee was assigned the task of devising a workable and fast means of notifying members out in the state when their help is needed on national legislative matters, in order that individual telegrams may be sent to the members of Congress.

*Dr. Frank B. Ramsey*, editor of *THE JOURNAL*, made the following recommendations:

1. That the Council elect the Editorial Board members at the summer Council meeting, so that the new members may be notified in time to attend the fall meeting of the Editorial Board. (Dr. Ramsey explained that in the past Editorial Board members have been elected at the fall Council meeting; the only Board meeting during the year is held the day following election; new members, as a rule, cannot be notified of their election in time to attend that meeting; hence they work almost a year before they attend a Board meeting.)

On motion of Drs. Bibler, Vye and Miller, the Council approved of the election of Editorial Board members at the summer meeting of the Council, in order that they may take office and attend the fall meeting of the Board.

2. That an Editorial Board meeting be held at the same time of the spring meeting of the Council, in order that the Board members may get acquainted with the Council.

The Council took no action on this second recommendation, expressing the feeling that the Editorial Board had the privilege of meeting at any time and place it desires.

*Dr. Cleon A. Nafe*, A.M.A. delegate, reported briefly on the actions taken by the House of Delegates of the American Medical Association at the San Francisco session, June 21-25, 1954.

### Unfinished Business

1. *Election of Editorial Board members.* On ballot vote, Dr. George M. Johnson, Richmond (surgeon), and Dr. Irvin W. Wilkens, Indianapolis (internal medicine), were elected members of the Editorial Board for three years, to succeed Dr. Richard H. Miller, Fort Wayne, and Dr. George M. Cook, Hammond, whose terms expire December 31, 1954.

2. *Report of the Special Committee to Consider Extension of Annual Convention Extra Day* was deferred to the October meeting of the Council.

3. *Report of Council Committee on Educational Affairs, including Postgraduate Study and Preceptorships.* Dr. Dodds, chairman of this committee, reported that he had been in correspondence with Dr. VanNuys regarding the medical economics course which had been dropped from the medical school curriculum, and he called upon Dr. VanNuys to outline the school's plans in this respect. Dr. VanNuys asked Dr. Don Wood, chairman of the Department of Medical Economics and Postgraduate Instruction, to speak on this subject. The course will consist of six or seven lectures, covering all phases of establishing a medical practice, including insurance, banking, credit, investment plans, book-keeping, affiliation with hospitals and medical societies, etc. Dr. Denny, chairman of the Committee on Medical Education and Hospitals, asked that tape recordings be made of the economic lectures, in order that men out in general practice might benefit from them.

Dr. Wood also spoke of the postgraduate courses which are sponsored by the university, and asked for suggestions from the councilors.

4. *Complimentary JOURNAL subscriptions for senior members.* Dr. Kennedy, chairman of the Council Committee on Miscellaneous Business, to which the matter of sending *THE JOURNAL* gratis to senior members was referred, reported that the committee was against sending *THE JOURNAL* to senior members free of charge.

Dr. Bibler read the following letter regarding this matter:

"July 2, 1954.

"Lester D. Bibler, M.D.  
Councilor, Seventh District  
Indianapolis 4, Indiana

"Dear Doctor Bibler:

"We have noted that the agenda for the July 25 meeting of the State Association Council lists an item calling for discussion concerning free *JOURNAL* subscriptions for senior members of the State organization.

"We are writing to you as our district councilor urging that you support the proposition calling for the State Association to provide *THE JOURNAL* free, not only for senior members but



also to those members whose dues are remitted by the Council for reasons of illness or disability.

"In the case of the senior members, it seems to us that a man who has paid dues to his Association for the long period required should, at least, receive a free JOURNAL subscription. To cut him off, unless he or his component Society pays, appears to be a bit abrupt and coldhearted. True, such free subscriptions would cost the State Association, but we cannot believe that the amount involved would be any great source of financial embarrassment when the healthy balances on hand are considered.

"In the case of those members whose dues are remitted because of illness or disability, we believe the same general thought applies.

"We realize full well that the State Association is a large business operation and economy in operation is to be applauded. However, it is not a business operation for profit, and service to its members should be of prime consideration. This certainly would seem to apply to those older doctors who have faithfully paid their dues for so many years.

"The Indianapolis Society, of course, pays for JOURNAL subscriptions to senior members and to those whose dues have been remitted. It costs the Society something like \$250.00 each year to do so. Frankly, we don't believe it is our primary obligation to provide these subscriptions. After all, THE JOURNAL is the property of the State Association and that organization should be the one to make this gesture to the older doctors.

"Very cordially yours,

EXECUTIVE COMMITTEE,  
INDIANAPOLIS MEDICAL SOCIETY

RUSSELL J. SPIVEY, M.D., President  
MORRIS E. THOMAS, M.D., Vice-President  
WILLIAM H. NORMAN, M.D., President-Elect  
A. T. STONE, M.D., Secretary-Treasurer  
HARRY PANDOLFO, M.D., Council Chairman"

Dr. Kennedy moved that THE JOURNAL not be furnished to senior members free of charge. Motion seconded by Dr. Hayes.

Dr. Denny, chairman of the Executive Committee, read the following from the minutes of the May 23, 1954, meeting of the Executive Committee:

"On the basis of 1952 publication costs, it would cost \$2,607.60 a year to send THE JOURNAL free to 265 members of the Association. Anticipating an increase in cost for the coming year for publication of THE JOURNAL, it is estimated that the cost to give THE JOURNAL to 265 senior members would be \$3,180.00. By consent the committee felt that this would be unwise, but would reserve any action by the committee until the matter came before the Council at the July meeting."

On voting, Dr. Kennedy's motion was carried.

5. *Medical Education Foundation Fund.* Dr. Denny, chairman, reported that Indiana University School of Medicine had received a check from the National Foundation for this year for \$49,300.00 plus.

The committee will conduct another mail campaign to each and every member in the state, starting probably in September, and ending in October.

6. *"Senior Day."* Dr. Dudding, chairman of the Committee on Rural Health, reported that his committee felt that "Senior Day," a dinner meeting for senior medical students and their wives or guests, held on May 1, at which time several prominent speakers appeared and talked on the advantages of rural medical practice, was a very successful and worthwhile project, and the committee feels that this should be made an annual event.

#### New Business

1. *Matters referred to Council by Executive Committee:*

a. Interpretation of "major fraction thereof" in Chapter IV, Section 2, of Bylaws, which reads:

"Each component county society shall be en-

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titled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof . . .

"The number of delegates to which each component society is entitled shall be based upon the number of members on record in the office of the executive secretary in good standing with current dues fully paid as of December 31 of the preceding year."

Dr. Denny explained that the Executive Committee had received a letter from the Lake County Medical Society relative to the number of delegates to which the society is entitled for the 1954 annual convention, the society claiming that inasmuch as it had 325 members on December 31, 1953, it is entitled to seven delegates. One of the association attorneys had ruled that a "major fraction thereof" is 26.

On motion of Drs. Howard and Vye, the Council concurred in the ruling of the attorney that a "major fraction thereof" is 26 members rather than 25.

2. *Conflicts in district meeting dates.* Dr. Denny reported that it is the feeling of the Executive Committee that the dates for district meetings could be set a long time in advance and each district could have a more or less established date from year to year, thus avoiding the many conflicts that occur under the system currently in use. This year four district meetings were held on the same day.

Following discussion by Drs. Denny, Howard and Garner, on motion of Drs. Howard and Dodds, the Council voted to "appoint a committee to study this matter and to contact the various districts and suggest a definite date for their meetings." (Following the Council meeting the chairman appointed the following committee to work out a program and bring in a report to the October meeting of the Council: Dr. Minor Miller, chairman; Dr. Maurice E. Glock and Dr. Wemple Dodds.)

3. *Election of members to Trust Committee of Indiana Medical Education Foundation.* On nomination of Dr. Dodds, Dr. Don Wood was elected to fill Dr. C. J. Clark's unexpired term ending October, 1954. On nomination of Dr. Miller, Dr. Don Wood was elected to succeed himself for the three-year term, November 1, 1954, to October 31, 1957.

By consent, Dr. Roy Geider was elected to succeed himself for the three-year term, November 1, 1954, to October 31, 1957.

4. *Insurance compensation for radiologists.* Dr. Bibler read the following resolution which is to be introduced at the Miami session of the American Medical Association in December and which, on motion of Drs. Bibler and Dudding, was referred to the Council Committee on Insurance for study and action:

"WHEREAS: This House of Delegates has previously and on numerous occasions opposed the inclusion of medical services as hospital benefits in hospital insurance contracts and has urged that insurable medical services be covered as a part of medical care, with hospital benefits limited to insurable hospital services; and

"WHEREAS: Information at hand indicates a contract is about to be executed with the \_\_\_\_\_ under which diagnostic x-ray services in or out of hospitals shall be furnished as an insured service only when rendered by a specialist in radiology at the exclusion of internists, orthopedists, urologists, general surgeons, general practitioners, and others who may own and operate their own x-ray equipment; and

"WHEREAS: A contract of medical insurance which limits benefits to a particular specialty and restricts the right of other practitioners to be paid for like services is contrary to the best interests of patients and profession alike; now, therefore, be it

"RESOLVED: That this House hereby reaffirms its opposition to the inclusion of medical services as a part of hospital care in insurance plans; and be it further

"RESOLVED: That the House go on record as opposing the limitation of benefits in any prepayment plan in such a manner as to restrict payment of fees to a particular specialty for services that can properly be rendered by other competent and duly licensed doctors of medicine; and be it further

"RESOLVED: That the Council on Medical Service be and hereby is instructed to investigate this matter and take whatever steps it may deem necessary to obtain agreement from health and hospitalization insurance plans to comply with the principles herein set forth."

This resolution was discussed by Drs. Bibler, Nafe, Howard, Dudding and Clarke.

5. Dr. Glock presented two matters that had been brought to his attention by one of the county medical societies in his district:

(1) A letter was received by the county society from the State Board of Health calling attention to the 1949 law requiring the reporting on State Board of Health form the names of all blind persons in the county and giving information on the facilities the Board of Health had to offer. The society's comment was: "This is all very nice and has its value, but it never seems to occur to the Board of Health that we may prefer to refer our cases to private physicians. It is my view that the Board of Health is getting entirely too big for their breeches. Please carry this thought along to the next Council meeting."

(2) Feeling that something should be done about the \$5.00 registration fee—the members are not getting enough for their \$5.00.



The chairman announced that item (1) had been referred to the Council Committee on Rural Health, Health Forms and Special Health Agencies, Dr. Dudding, chairman, and item (2) was referred to the Council Committee on Miscellaneous Business, Dr. Kennedy, chairman, for consideration.

Following discussion, on motion of Drs. Kennedy and Miller, the matter of registration fee was laid on the table.

On motion of Drs. Miller and Dudding, item No. 1 was laid on the table.

6. *I. U. School of Medicine.* Dr. VanNuys announced that plans for a Science Building, costing approximately seven million dollars, will be completed by the first week in August and that a dormitory is also to be built on the north end of the Student Union Building. This will make it possible to bring the first year of medicine to Indianapolis.

Dr. VanNuys also announced that it will be possible to increase the enrollment in the freshman class this fall from 150 to 160. The Admissions

Committee and the Board of Trustees of the University have approved of this increase. Dr. VanNuys asked for approval of the Council on this recommendation.

On motion of Drs. Dudding and Bibler, the Council approved of enlargement of the freshman medical school class from 150 to 160 students and complimented Dr. VanNuys on his work and the remarkable improvement in the medical school.

*Dr. L. E. Burney*, State Health Commissioner and secretary of the Indiana State Board of Health for the past nine years, told of his leaving Indiana to return to the United States Public Health Service, and expressed his appreciation for the generous assistance given him by the Council, the officers, and the members of the state medical association.

No further business appearing, the Council adjourned, to meet again at 3:00 p.m., Sunday, October 24, 1954, at the Student Union Building, Indiana University Medical Center, Indianapolis.

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All articles must be typewritten, double-spaced, with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Only a limited number of illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication of THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

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## THE MONTH IN WASHINGTON

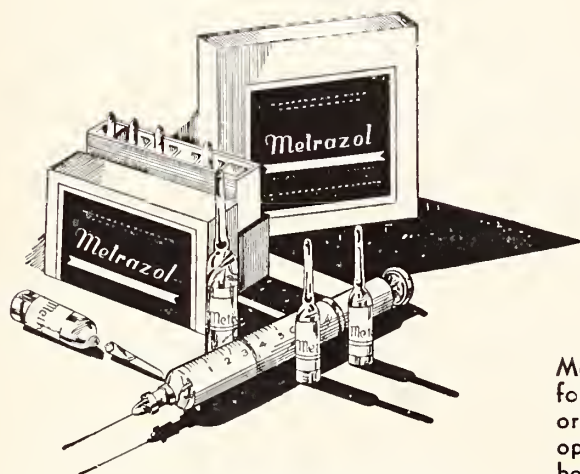
WASHINGTON, D. C.—When the 84th Congress convenes in January, the Eisenhower Administration will press for passage of at least two bills that failed to get through last session, reinsurance and a new program of medical care for military dependents. The former was decisively defeated in the House. The latter did not reach a vote in either chamber.

In a radio address summing up his Administration's legislative achievements, Mr. Eisenhower confirmed that he was prepared to renew the fight next session to have the federal government set up a system for reinsuring health insurance programs. He declared: "Health reinsurance we are going to put before Congress again

because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line."

There have been no indications how far the Administration would go in amending the reinsurance bill to satisfy its critics. It is possible also that if all objectionable features were removed there would be little left of the bill.

At Senate and House hearings, reinsurance was roundly denounced by most witnesses, for a variety of reasons. AMA's position was that reinsurance wasn't needed because private funds are available for the limited amount of reinsurance that could be used, and that in addition the



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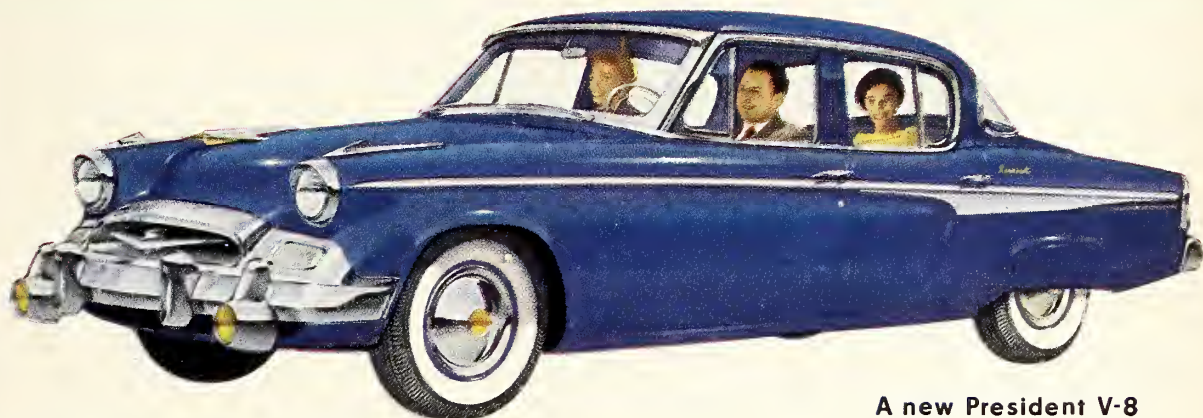
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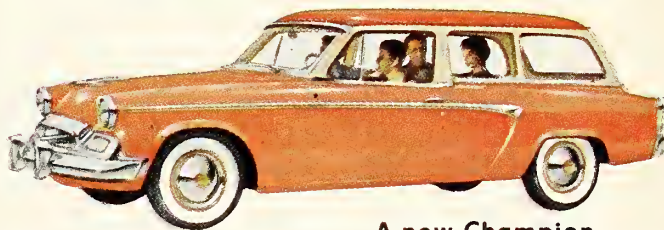


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## The Month in Washington—(Continued)

program projected the federal government too far in the direction of control of medical care.

Later in the session, Mr. Eisenhower himself and Mrs. Hobby made every effort to win over critics of reinsurance, and to force the bill through Congress. In the light of these efforts—including a nationwide radio appeal by Mrs. Hobby—the defeat of the bill in the House of Representatives was regarded as one of the most surprising suffered by the Administration on any domestic legislation.

Currently Secretary Hobby and Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee are attempting to bring together all parties interested in health legislation to see if a compromise can be worked out on reinsurance.

Although the dependent medical care bill wasn't passed, this fact was not in any way regarded as a defeat for Mr. Eisenhower. The bill was offered in the Senate in plenty of time for

action, but the introduction of the House bill was held up until Defense Department could estimate the first years' cost, eventually set at \$67 million. At any rate, neither Senate nor House Armed Services Committee held hearings on the measure.

In another statement, Mr. Eisenhower made it clear that he expects the next Congress to do something about improving and making more uniform the system of medical care for servicemen's families. Congress, he said, "must eventually meet certain imperative needs of the members of the armed forces." He explained that servicemen now "lack adequate medical care for dependents. . . . It is most important that these needs of the armed forces personnel serving their country often in remote corners of the world engage our serious consideration."

Although the American Medical Association has not had an opportunity to testify on the dependent care plan before Congressional com-

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## The Month in Washington (Continued)

mittees, it has made its views known to the Defense Department. In general the AMA is not opposed to Defense Department proposals that a more uniform system be worked out, and that the federal government bear most of the cost. On one important point, however, the recommendations of the department and of the Association are in direct conflict: The department would have the military medical departments themselves furnish dependent medical care wherever they could, with service families going to private physicians and private hospitals only where the uniformed physicians couldn't handle them. The Association, on the other hand, proposes that dependents be cared for by the military medical departments only where civilian medical facilities are inadequate to furnish proper care.

Federal officials, meanwhile, are busy preparing to put into effect the new health bills passed by Congress. Basic state allotment percentages have been worked out for the new Hill-Burton program (for facilities other than complete hospitals) and for the expanded vocational rehabilitation program. The Internal Revenue Bureau is about to issue detailed instructions to taxpayers regarding changes in medical expense deductions and other benefits in the new tax law.

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# The *Journal*

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## Anterior Sacral Meningocele

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LEON J. WITKOWSKI, M.D.

*Chicago*

**T**HE VARIED EMBRYOLOGIC DEVELOPMENT of the sacro-coccygeal region results in its being the frequent site of abnormal cell aggregates. If these potential tumors involve the dorsal aspects of the sacrum they are easily recognized. If however, they rest along the ventral aspect they may remain dormant and unsuspected for many years. The resulting tumors are usually classified as a dermoid, teratoma or chordoma. One must also remember that an anterior sacral tumor can be a meningocele with direct thecal communication. This possibility always deserves consideration because operative intervention has frequently led to meningeal contamination and death.

Anterior sacral meningocele occurs more frequently in women. The ratio in reported cases is 24 to 4. Recognition of an anterior sacral mass is usually diagnosed before 40 years of age, and is suggested by low back pain, obstipation, prolonged labor and other signs of low pelvic pressure. Cases with a neurologic deficit of the lower sacral segments have been reported. By rectal examination a compressible mass is easily palpated in the sacral concavity, and this

finding when coupled with coincident fever has repeatedly led to ill-advised surgical drainage. Lumbo-sacral x-rays have aided in establishing the diagnosis. There is almost always some sacral deformity. Absence of the left lateral half of the sacrum has been the most constant finding, and this has resulted in the term "scimitar sacrum." Pantopaque myelography with pooling in the inferior sac is pathognomonic.

In 1943, Collier and Jackson<sup>1</sup> sounded a note of warning. They reviewed 23 cases of anterior sacral meningocele and included one of their own. Eighteen of the 23 previously reported cases were surgically treated with a mortality rate of 44 per cent. The usual cause of death was post-operative meningitis.

This grim figure emphasizes the importance of recognition. Shidler and Richards<sup>2</sup> added three cases to the literature, but only one was surgically treated. Posterior excision was successful. Brown and Powell<sup>3</sup> recently reported the pre-operative recognition of anterior sacral meningocele and its successful posterior excision. They introduced the use of pantopaque myelography in establishing the diagnosis.

We have recently encountered a case of anterior sacral meningocele. The case was of clinical interest because of its typical history and

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\* From the 4th Surgical Service, St. Luke's Hospital, Chicago.

because of an associated peri-anal abscess. The patient had undergone five rectal operations for its cure, anyone of which could have resulted in death. Subsequent excision of the meningocele revealed its independence from the fistulous scars. It could be reasonable to assume that fistula in ano would commonly develop in patients with anterior sacral tumors. The associated obstipation and increased defecatory pressure would offer such a predisposition. Herein, lies a very real danger.

Mrs. L. M., a 30 year old white female, entered St. Luke's Hospital on July 7, 1947. At 11 years of age she was troubled with rectal pain and drainage which continued intermittently for 10 years. She was completely well between the ages of 21 and 25, but following a very difficult childbirth she developed recurrent rectal difficulties. During the five years preceding this admission she had undergone five rectal operations for peri-anal abscess. The last procedure in January 1947 was followed by a cessation of drainage but she continued to complain of low back pain and obstipation.

Peri-anal inspection revealed a patulous anal outlet. The scars of previous surgery were noted, the most extensive fibrosis was along the posterior midline. The sphincter was lax but functionally adequate. There were no external draining sinuses. Digital examination was not painful and palpation revealed an easily compressible grapefruit size mass lying in the retro-rectal space. The rectal mucosa was normal.

X-rays revealed a peculiar architecture of the lower sacrum and coccyx. The coccyx was displaced to the left, and the lower sacral segments showed a large central defect. A soft tissue mass could be seen extending anteriorly to the sacrum in immediate relationship to the aforementioned defect. The lumbar vertebrae were completely normal. Myelography was considered and rejected. Neurologic examination revealed no abnormalities.

Surgical excision was deemed advisable. She was carefully prepared and on the fifth hospital day was taken to surgery. The patient was placed in the prone jack-knife position, and a generous post sacral incision from S-2 to within one inch of the posterior anal border was made. The deviated coccyx and central sacral defect allowed easy access to the retro-rectal space. The glutei were retracted laterally and the large cystic mass

was peeled from the posterior rectal wall. In freeing the sac, it was inadvertently opened with the escape of 350 cc. of clear, colorless fluid. The sac lining was smooth. As the dissection proceeded superiorly, the sac narrowed greatly as it approached the central defect in the sacrum. At this level, it was amputated following suture ligation of the base with silk. The wound was closed loosely as in the perineal portion of the usual abdominal perineal resection. The retro-rectal space was lightly filled with drawn gauze and the skin edges approximated with silk. On gross inspection, this meningocele measured 20 cm. in length and 12 cm. in width. Its wall was moderately sacculated and varied in thickness from 1-6 mm. Histologically, there was the usual hyalinized, coarse, fibrous tissue characteristic of all previously reported cases. The patient's convalescence was uninterrupted. She was given both penicillin and streptomycin, but the pre-operative sulfathalidine was not resumed. She was discharged on the sixteenth post-operative day.

This case is of interest because it emphasizes the dangers in unrecognized anterior sacral meningocele. The patient had five rectal operations directed toward the cure of a posterior fistula in ano. Anyone of the procedures could have resulted in meningitis and death.

## CONCLUSIONS

(1) Anterior sacral meningocele is a rare condition. Its high mortality following surgical interference is due to failure of recognition.

(2) It may be suspected in cases of pelvic pain, obstipation, complicated childbirth and possibly chronic rectal fistulae.

(3) The presence of an anterior sacral mass, x-ray evidence of sacral deformity and pantopaque myelography should make the diagnosis certain.

(4) Posterior excision is most satisfactory.

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# A Summary of 1,850 Vein Operations with 35 Cases of Saphenous-Perineal Anastomosis



Figures 1 and 2, left and center above, show severe types of varicosities; Figure 1 with deep ulceration.



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**T**HE PURPOSE OF THIS PAPER is to review a series of 1,850 consecutive operations for the treatment of varicose veins; to describe a type of perineal backflow which is not generally recognized, and to emphasize what has been of most importance in the successful control of recurrent varicosities.

In this series there have been no deaths, no amputations, and no known emboli. There *have* been some radical changes in method of treatment during the 14 years in which these observations were made.

The treatment and cure of varicose veins has been one of



Figures 3, upper right, 4 and 5 and the diagram at lower right illustrate perineal vein breakdown. "X" in the diagram indicates an unnamed vein (found in 35 instances in this series) which is a definite entity.



our most difficult to stabilize and to standardize. Good methods have been discontinued or even condemned, only to be resurrected nearly 50 years later and now to be considered essential.

In 1905 Keeler advocated vein stripping and in 1906 Mayo devised a similar stripping procedure. They did not ligate the saphenous vein and its tributaries at the fossa ovalis, and consequently their results were unsatisfactory.

The high saphenous section as now done was first advocated by Homans in 1916. It fell into disrepute, probably because of a high mortality rate, but was revised by Gaza DeTakets, whose additional contribution was insistence upon the patient's immediate and continued ambulation.

There were tests and operations advocated for control of leaking communicating veins; there were many agents used for injection of veins to cause their occlusion by sclerosis; the short saphenous vein breakdown was described, as well as a surgical technique for its control.

When used individually, none of these methods of treatment could be considered adequate, yet all have merit and in many cases all must be used to insure permanent relief from varicosities.

We now may hope that by employing all of these methods we finally have arrived at a fairly well recognized method of procedure, namely, careful high saphenous section, being sure to isolate and interrupt all high tributaries in the region of the fossa ovalis, then the stripping of the main saphenous trunk and all other superficial veins down which the stripper may be passed. The communicating veins are severed either by pulling them away from the saphenous trunk, or, better, by cutting down on them and ligating at the time the saphenous is stripped. If the short saphenous vein permits backflow, it must be dissected at the popliteal space and sectioned where it dips to enter the popliteal vein. It may not be possible to strip or resect all veins; if not, those veins remaining may be successfully occluded by injection.

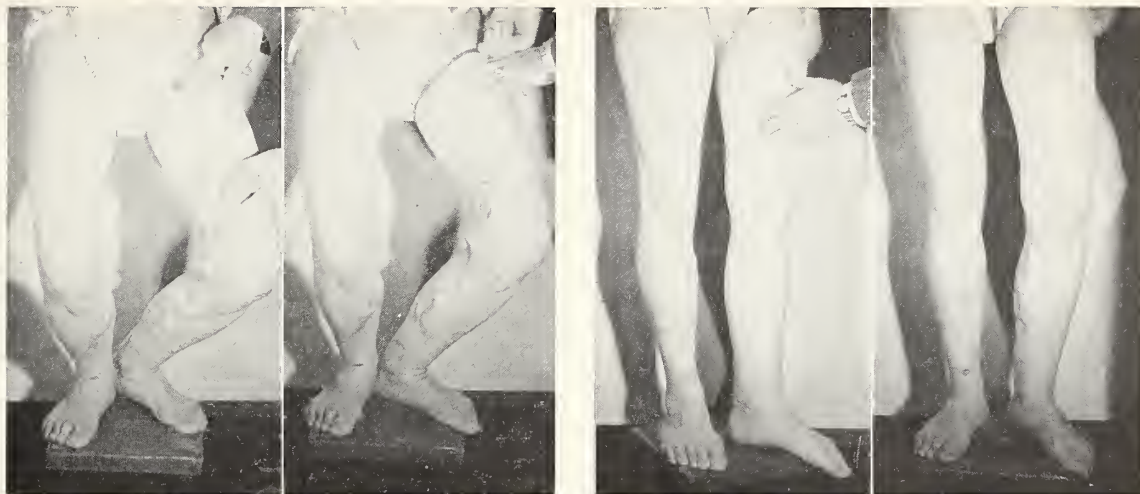
Failure or delayed recurrence may still be the result if the aforementioned procedures are carelessly or inadequately applied. The commonest cause of failure stems from overlooking a high tributary in the region of the fossa ovalis. Failure to section the femoral circumflex branch, for example, may cause recurrence of varicose

veins, in spite of high section, stripping, short vein section, communicating vein section, or injection. The importance of doing the high section thoroughly and properly cannot be over-emphasized.

### 35 Cases of Backflow and Anastomosis from the Perineal Region

It has been interesting to note that there are still failures in a small percentage of cases when all of the above mentioned methods have been used to maximum efficiency. About two per cent of these failures have been due to a type of anastomosis between perineal or hemorrhoidal veins and the veins of the inner side of the thigh. To our knowledge this has not been recognized nor considered as a definite entity in formation or recurrence of varicose veins. Thirty-five such cases were detected in this series of 1,850 consecutive vein operations. Generally these veins present a fan shaped pattern which enters the perineal, labial and hemorrhoidal vessels. They converge on the inner upper aspect of the thigh into a single vein, may spiral downward and laterally on the thigh to the outer side of the leg and ankle, or this vein may simply anastomose with the saphenous trunk or its tributaries on the inner aspect of the thigh.

Thirty-two of the 35 cases of perineal vein backflow were found to be associated with long saphenous breakdown. Following long saphenous section, this unusual location of venous backflow became very much more pronounced. The other three cases of this group presented no evidence of saphenous backflow whatever and showed varicose veins only along the course of this unusual vein as above described, from perineum to the back of the thigh, then to the outer side of the leg and ankle. This source of backflow comes from within the circle of the bony pelvis, rather than external to it, as is the case in saphenous backflow. It has been gratifying to find that all cases were controlled by dissection of these veins in the perineal region. Some have required hemorrhoidectomy along with multiple section of dilated labial veins. Some have required a second operation to interrupt all of the sources of backflow. The interruption of perineal veins is not so difficult as high saphenous vein section.



The series of photographs, above, illustrate steps in Perthe's test. The third picture, taken after the patient had bent his knees a dozen times, shows veins collapsed. In the last picture, the tourniquet has been released and veins are again distended from downward pressure.

### Treatment of Varicosities

The cases here reported have been operated over a period of 14 years, and during these years our conception of proper treatment has changed. One thousand six hundred cases were done before routine stripping was accepted as desirable. By and large the results were very gratifying. Recurrences were handled as they appeared, usually by multiple section of communicating veins, which amounts essentially to a vein stripping. Ulcers have usually remained healed or responded to communicating vein section.

One to two per cent of stubborn recurrence has been encountered in the series, in spite of all treatment employed. Usually those individuals have had exceptionally bad veins; the majority gave a history of deep phlebitis and many were aggravated by constant standing during the course of employment.

No procedure can be completely standardized when it must deal with the marked individual variations encountered in the venous anatomy. Not all surgeons will approach the problem in the same way, and as we enumerate steps and

Below, usual anatomy at level of fossa ovalis.

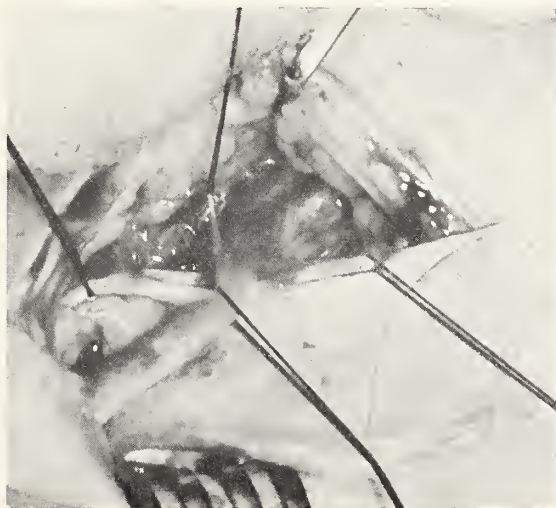
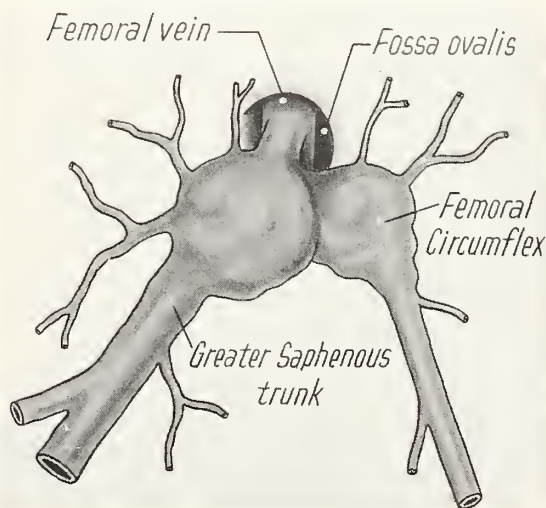


Diagram shows type of variation frequently found showing two trunk veins and high varicosities.





methods, it will be only a presentation of what has been most successful and practical for us:

(1) *Selection of cases.* So much has been written describing Trendelenburg and other tourniquet tests that it need not be repeated. The deep circulation may be checked by Perthe's test or wrapping from the groin downward with ordinary surgical gauze. We have arbitrarily waited at least two years following a suspected deep phlebitis before doing a high saphenous section. It is a rare occurrence when tests have indicated that high section could not be safely done.

(2) *High saphenous ligation.* The femoral pulse is used as a landmark and two per cent novocaine with adrenalin is injected from this point medially for two inches. An incision is made one-fourth inch below the fold of the groin. The high tributaries will be missed if the incision level is too low, and missed tributaries are the commonest cause of uncontrollable recurrence. The saphenous trunk is dissected free at the site of the fossa ovalis and the femoral vein is identified through the ovalis. All high tributaries, which may vary in number from 2 to 15, are then ligated with fine silk, and divided. The trunk of the saphenous is then ligated and divided, using double zero silk and a double ligature. The vein must be ligated high at the fossa ovalis, leaving no long stump for possible emboli formation.

(3) *Stripping.* Stripping is now practiced as routine. The legs are prepared from the abdomen to the feet and the high section is done, using local infiltration. For the stripping, the patient is given sodium pentothal anesthesia and is placed in moderate Trendelenburg position. We feel that this position of the patient during the stripping operation is important to reduce hemorrhage and extravasation of blood in the tissues. A flexible stripper is then inserted into the lumen of the vein, the downward course of which can be traced through the skin. The stripper may enter a small tributary or venous pouch and may be pulled backward and forward until it again is felt and seen to be within the main trunk. (The type of stripper used is not important. The best one we have is made from a bass guitar string with one small and one large olive tip soldered on the two ends.) In a great many cases the stripper may be seen to reach the inner side of the ankle. Novocaine is in-

jected over the tip of the stripper, an incision is made and the vein elevated. A catgut ligature is placed distal to the olive tip, the vein is cut and the stripper pulled through. As the large knob of the stripper is pulled down the thigh, its course may easily be followed. Strong resistance is usually encountered about four inches above the knee. Novocaine is injected and an incision made; the large knob with the telescoped vein is brought out, and communicating veins and large tributaries are identified. Communicating veins are ligated with catgut and cut free. Large tributaries are clamped and examined and if a stripper can be passed, they, too, should be stripped. The same procedure will be carried out about four inches below the knee; two or three large tributaries may be encountered here which may be stripped. Pressure pads are applied and held in place just back of the stripper as it passes downward, thus controlling the hemorrhage which follows the separation of the smaller tributaries along the course. The entire saphenous vein may then be pulled out at the ankle and telescoped over the stripper. Large tributaries are stripped in like manner. Novocaine is used at points where the skin is incised, to reduce the quantity of sodium pentothal required.

All incisions are then closed with two zero catgut. Sterile gauze and pressure pads over the course of the saphenous vein are encircled by eight inch elastic bandage, wrapped from ankle to groin.

The use of sodium pentothal as an anesthetic agent permits early recovery from anesthesia in the patient and after 20 or 30 minutes he is usually able to walk, with assistance. The principle of early ambulation must be emphasized. It is our safeguard against deep vein thrombosis. The patient may leave the hospital in from one to three days, depending on circumstances, general condition and severity of veins.

Following stripping the patients were found to suffer much less postoperative discomfort and systemic reaction than those who received injection at the time of high ligation and developed thrombosis and chemical phlebitis. Patients experienced less painful convalescence after stripping and were able to return to work earlier. We feel that stripping as an adjunct to careful high section will definitely reduce the recurrence rate.



The patient reports to the surgeon's office a week following surgery. Other channels may be found to be still open, and injection will then be required. Occasionally a communicating vein will be found still leaking; there may also be a short saphenous vein evident which was not apparent before and it will require section. The unusual type retrograde flow from the perineal region may also become more apparent if it is present.

### Questions and Answers

Where this problem has been presented for discussion before medical groups, there have always been questions representative of problems confronting the man in general practice. Let us enumerate and attempt to answer some of these questions:

- (1) What is the cause of varicose veins?

**Answer:** Basically it is a failure of valve function at the saphenous femoral junction. Heredity, multiple pregnancies, constant standing, and deep phlebitis are contributing factors.

- (2) Are varicose veins found in men as well as women?

**Answer:** Yes. Varicose veins are more prevalent in women in a ratio of about six women to four men. Pregnancy definitely adds stress and strain on the valves of the saphenous femoral junction.

- (3) Can varicose veins be treated successfully with injections?

**Answer:** Only if veins are of superficial spiderweb variety. Operation may do these no good whatever, and injection may be the only means of control. Check for large veins and retrograde pressure by using Perthe's test.

- (4) Can a pregnant patient be treated for varicose veins?

**Answer:** Yes, during the first half of pregnancy. Avoid surgery at the time when her period would have fallen. Advise elastic stocking support during last half of pregnancy, then surgery two to three months postpartum.

- (5) Can the patient who has a varicose ulcer be operated before the ulcer heals?

**Answer:** Definitely yes. Ignore the ulcer. If operation is indicated, the ulcer usually heals quickly after surgery.

- (6) May an elderly patient with varicose veins be operated?

**Answer:** Several patients over 80 who have insisted they wished to continue active work have been safely and satisfactorily operated.

- (7) Can patients with a history of deep phlebitis be operated?

**Answer:** Yes. Generally such patients develop varicose veins. It must be made clear to them that the deep vein has been permanently damaged. Their condition may be markedly improved when vein section is indicated and this may be especially true when ulcer is present. There appears to be no complete cure for the swelling and heaviness caused by deep phlebitis.

- (8) Can varicose veins be operated in the office?

**Answer:** No. It requires an hour for each leg operated; the surgery is painstaking, extensive, and when stripping is done requires general anesthesia.

- (9) How dangerous is the operation?

**Answer:** This report and others indicate that the procedure is less hazardous than most surgical procedures. No deaths have occurred in this reported series of 1,850 cases.

- (10) Do all cases require postoperative injections?

**Answer:** No. The marked individual anatomical variations permit no hard and fast rules in methods or results of treatment. Many patients require no injections; a few patients may require from 20 to 25 injections, even when the radical stripping procedure has been done.

- (11) Where injections are given, what solution is used?

**Answer:** This varies with the operator. At present, Sotrodeckel is being used, one per cent for very small superficial veins, and three per cent for the larger varicosities.

- (12) Are varicose veins covered by Workmen's Compensation?

**Answer:** Usually not. Constant standing at work may aggravate the varicose veins, but this is not considered accidental and therefore not compensable.

- (13) What about the use of bandages, drugs, and Una paste boots for varicose veins?

**Answer:** All these may help control ulcers. However, if the Perthe's test is positive and a definite valve failure is present with back pressure, the patient must be operated if any permanent relief is to follow. Some patients who have to continue long working hours in standing position will benefit by using elastic support even after all surgical and injection procedures have been done.

- (14) What about the hazard of embolus?

**Answer:** Apparently it constitutes only a very slight hazard. Early and continued ambulation is considered the best safeguard against emboli.

## SUMMARY

One thousand eight hundred fifty cases of consecutive vein operation have been reviewed. No fatalities or amputations resulted, and results have been gratifying. During the past two years stripping has been adopted as a part of the routine procedure. The careful high section of the saphenous vein is still considered the most essential element.

Thirty-five cases of backflow from the perineal region were encountered. This represents an entity seldom recognized. All cases responded to surgical excision and section of the affected veins.

# Psychosurgery in the Logansport State Hospital

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**P**SYCHOSURGERY in a state hospital is concerned with a different type of patient, and is performed for different indications than is the same type of surgery in private practice.

In a community it is usually the psychoneurotic patient for whom psychosurgery is done.

In a state hospital it is the chronic schizophrenics who are considered for surgical treatment. The ones chosen for this form of therapy might be classified as "last resort" cases—all of them have had the usual treatment by insulin coma and electro-shock without substantial improvement.

The average duration of illness of the schizophrenic patient operated upon is 11 years, and the average age is 40 years. They are idle, chronically disturbed or apathetic to the extent of being stuporous. They are the patients who chronically soil themselves, and who regularly strip off and destroy their clothing. They may be combative and require sedation.

The improvement which is sought and which lobotomy may accomplish may be of two varieties. Some are improved so much that they may be discharged to the care of relatives.

Others remain as institutional cases but are more manageable. They appear to be happier and are more cooperative. They develop cleanly habits and are not destructive.

The savings in property and in the personal care which they require may amount to thousands of dollars. They are frequently able to participate in rehabilitation measures such as

occupational therapy, and they may be able to engage in recreational activities.

One example is a patient who was secluded and screamed incessantly. She had become tolerant to sedation so that sedatives were practically useless. She was apprehensive of the food being poisoned. Following operation she accepts institutionalization well, has worked for months in occupational therapy, and is to be transferred to work in the laundry.

In the selection of cases with the exception of 3 or 4, no organic cases were selected. Practically all were schizophrenics of long standing. Patients who had been unimproved and were destructive, combative, soilers, homicidal or suicidal, idle, and sharing in no activities, or patients who were frankly stuporous. Patients also were transferred from other institutions for pre-frontal lobotomy because of being homicidal or chronic elopers. Where possible, other treatments had been tried as electro-shock therapy and insulin coma therapy. Patients requiring seclusion, restraint, and constant sedation who had not benefited by hydrotherapy and all of the patients on the chronic (bad wards) were screened for treatment.

For comparable situations justifying the application of psychosurgery to State Hospital patients, omitting research studies and work done upon a relative few patients such as the Columbia Greystone Series, we would briefly refer to work done in New York State and in New Jersey. In the latter instances, transorbital



lobotomy was performed upon 200 chronic patients of all diagnoses in a New Jersey State Hospital, also 650 patients who had been given pre-frontal lobotomies at Pilgrim State Hospital, New York, and 700 treated similarly in Connecticut State Hospital. In the latter instances reports and papers have been written covering observations over a 5 year period. Yale psychiatrists in various articles have described the Connecticut work.

All the hospital studies in which groups over 50 were used agreed essentially that one-third of the patients are furloughed or discharged out of the hospital and one-third or more show symptomatic improvement.

### MANNER OF SELECTION

The patients have been carefully selected. They are first screened by the hospital staff. Then the patients are seen by a final screening staff including Dr. E. Rogers Smith, Dr. John A. Larson, Dr. John Ferguson, a psychologist, Mr. Ralph Cary, and then referred to Dr. Ferguson for work up and scheduling for surgery.

Preliminary to surgery an intensive battery of laboratory tests are made. With the exception of pneumoencephalograms or angiograms which we perform in special cases the following procedures are routine.

- a. Preliminary psychiatric staff meetings.
- b. Laboratory
  - (1) E. E. G.
  - (2) E. K. G.
  - (3) Chest X-ray
  - (4) Blood typing
  - (5) Lumbar punctures and routine urinalysis and blood studies.
  - (6) Biochemical  
Blood Wassermann, lumbar puncture, urinalysis, blood counts, color index, Rh factors, bleeding and clotting time, blood sugar, non-protein nitrogen, urea nitrogen, total protein, chlorides, cholesterol.
- c. Psychological Testing Consists of
  - (1) Wechsler Bellevue Form I
  - (2) Sequin Form board II
  - (3) Rorschach
  - (4) Draw a person
  - (5) Bender Gestalt

These tests are performed before and after when the patient can cooperate. This paper treats the psychosurgical aspect primarily. Detailed summaries of personality factors, E. E. G. findings and other laboratory findings, including psychological tests and predictions are withheld and will be published in other communications.

The following table is suggestive but not final and as time goes on there will be more furloughs. Patients now at the furlough level may be held pending satisfactory placement.

232 patients had had lobotomies when this paper was prepared.

Discharged or			
furloughed	-----	46	or 20%
Improved	-----	155	or 66%
Unimproved	-----	31	or 14%

As of November 18, 1953 we had operated 47 patients using the new transorbital technique.

Furloughed or furlough level	----	3
Improved	-----	38
Unimproved	-----	6

In the literature you will find statements saying that as high as 30% may become soilers post-operatively, that as high as 30% may have seizures post-operatively and that the death rate may run as high as 7%.

We would like to give you our observations on these points: First, as to the possibility of 30% starting to soil post-operatively, we do not have a single new case of soiling which originated post-operatively and of the 64 soilers we have operated, 55 have stopped soiling spontaneously or with some training. Next, as to the possibility of 30% developing post-operative convulsions, we have had 3 patients with post-operative seizures, yet today we have none with seizures and none of any form on anti-convulsive medication. Then finally, as to the possibility of a 7% death rate, as of November 18, 1953 our rate was slightly over 2%, although we had not had a death in the past 162 operations.

We also feel that the results will continue to improve following our perfection of new techniques, for both the orthodox and the transorbital approach. We started using them in June 1953.

### TECHNIQUE

The first few cases had the open form or orthodox lobotomy. We soon began to use

routinely the transorbital lobotomy using the Freeman technique. Since June 1953 a modified transorbital is done and we feel we are getting as good results with this as with the more radical operation. If this continues to prove out it will be a great advantage in the State Hospital. By eliminating many orthodox lobotomies more patients can be operated in less time with patients up and about sooner thus cutting down post-operative care. If the transorbital does not prove satisfactory then the orthodox lobotomy is available. A lot of credit goes to Dr. John Ferguson of the Logansport State Hospital staff in connection with this modified transorbital technique.

The technique is as follows: After the usual preparation the lids of one eye are held open with an eye retractor. The point of the pick is placed against the orbital roof and while held parallel with the nose is driven in until the 5 cm. mark is opposite the edge of the upper eyelid. The handle is moved laterally until it almost touches the outer canthus then it is returned to the midline. The pick is driven in to the 7 cm. mark and the handle moved laterally 10-15 degrees and elevated until it impinges. It is then moved medial to midline and back to position parallel with nose. The handle is then moved medially until it almost touches the nose then again elevated until it impinges and then moved back to the midline and down as far as it goes. Before removing the pick the handle is depressed and moved medially and laterally 10-15 degrees each way. The procedure is repeated on the other side.

With the above described maneuvers we feel a maximum transorbital lobotomy is done thus giving results similar to the open operation.

### REPRESENTATIVE CASES

#### S. W.

Admitted June 10, 1952.

3 Admissions since 1940.

Diagnosed as Manic Depressive, Manic.

*Transorbital lobotomy June 4, 1953.*

*July 1, 1953*—The patient was friendly and receptive, saying that she felt fine. Speech was coherent and the patient's thinking was rational, behavior was absent of mannerisms.

*September 17, 1953*—Marked improvement. She now works in the cannery.

*September 29, 1953*—Furlough granted.

#### V. V.

Female 39 years old, admitted August 29, 1951.

Schizophrenic paranoid.

On March 20, 1952, following the termination of 60 insulin coma treatments it was felt that she had only shown throughout her stay here transitory improvement and on March 27, 1952 psychosurgery was decided upon and a transorbital was performed on April 5, 1952.

She steadily improved until her furlough on August 2, 1952 and has done well since.

*June 16, 1953*—patient returned to hospital for post lobotomy testing. She was neat in appearance, but somewhat hesitant in social contacts. She functioned very well during the test period and some of her shyness disappeared. She was quite concerned about obtaining her final discharge papers and was referred to social service. Her brother-in-law states that the patient has made an excellent adjustment on his farm, and is considered one of the most ardent workers about the premises. She not only does a large share of the housework but also assists in the planting and harvesting of the crops.

#### G. B.

Admitted at age of 28, in 1950, was diagnosed as schizophrenic, simple type. Before psychosurgery his behavior alternated until he became very disturbed. Following the first operation, transorbital April 24, 1952 he became apathetic and delusional and then very excited and combative, screaming at the top of his voice at times and required seclusion. Following the orthodox lobotomy June 26, 1952, he gradually improved, did well on the open ward. He was (in the month of September 1953) a different individual, pleasant, quiet.

Furloughed April, 1953.

#### Z. C.

Admitted July 19, 1949.

Five commitments New York 1945-1948. Described as being careless about her dress, demonstrated inappropriate affect, was elated and delusional.

*Pre-operative behavior*—Her speech was rambling and irrelevant. Her later behavior was described as combative. Her speech bubbled with

dramatic tone. She was euphoric and preoccupied with sexual matters. Was assaultive.

*March 20, 1952*—Transorbital post operative behavior—her behavior remained unchanged.

*June 12, 1952*—Orthodox post operative behavior has all changed. She shows interest in all activities and discusses her hallucinations.

*General Impression*—Some symptomatic improvement is in evidence and her overall improvement could be called very marked and was downtown recently with her mother shopping.

#### C. D.

First admission April 17, 1926.

Second admission November 20, 1931.

He shows some slight retardation. He holds some ideas of mind control. Describes active hallucinations. Voices would yell at him when he would be walking. Has the idea that a neighbor living in the other half of the cottage has been controlling his mind. Thinks he possibly has syphilis due to acts of sex perversion in younger years. He was diagnosed on the former commitment as dementia praecox, hebephrenic type, but the fact was not overlooked that there were many outstanding features which would point toward its being catatonic type.

*April 24, 1952*—underwent transorbital lobotomy.

*April 29, 1952*—No post operative improvement was noticeable in this patient.

*Orthodox lobotomy on June 12, 1952.*

*July 22, 1953*—Employed in the cannery. The patient was cooperative and well adjusted and doing well in rehabilitation.

#### H. B.

Age 24, admitted July 28, 1952.

Diagnosis: Schizophrenic catatonic. This patient was in an excitement and after killing a patient at the Evansville State Hospital was transferred to the Criminal Insane Division at Michigan City, Indiana. He was then transferred here, the reason being given "homicidal". He was very disturbed, screaming about killing. He was operated (orthodox lobotomy) on August 14, 1952. He soon quieted down and became a good patient. His schizophrenic symptoms continued but he was a cooperative patient and was transferred to be nearer to his mother August, 1953.

In concluding, we repeat that psychosurgery in a State Hospital is done for two reasons: to enable a patient to be discharged or to gain symptomatic improvement so they may make a better adjustment to hospital life.

Abstracts of some of the cases have been presented but no attempt has been made to compare the results obtained from the different technique of transorbital used because not enough time has elapsed since the new technique was started to enable evaluation.



# Incidence of Intestinal Side-Effects with Tetracycline\*

GEORGE E. GATES, M.D.†

*South Bend*

**T**HE PURPOSE of this report is to record the results of treatment with Tetracycline\* of a miscellaneous group of acute infections, with particular reference to the incidence of gastrointestinal side-effects.

Tetracycline is a new drug, similar to Chlorotetracycline\* except for the absence of one chlorine atom. Animal and human studies have shown it to have about the same broad range of effectiveness as Chlorotetracycline and Oxytetracycline\*, and the dosage and lack of toxicity are also the same. These features were not investigated by me, except that it was noted that the response of the infections treated was clinically no different than with these other two broad antibiotic drugs.

One hundred cases were treated in the four months from late August 1953 (Tetracycline became commercially available in November 1953). These cases were all office or home patients, seen in the ordinary practice of internal medicine, and were unusual only in that five cases of amoebiasis were treated during that time. Amoebiasis was endemic in a local factory at that time. Incidentally these cases, plus one case of acute brucellosis, responded well to this treatment, without any relapses, clinical or laboratory, to date.

Of the 100 cases, only one patient had diarrhea, and this was moderate and of few days duration. However, eight other cases noted slight looseness of the stools, with one to three stools per day, during treatment, and promptly ceasing at end of therapy. Two of these had a

second course of Tetracycline, for a separate and different illness, without any looseness of stools, and it is presumed that the looseness of the stools was part of the illness rather than the treatment.

None of these cases requiring large doses, such as 2 gms. per day for up to three weeks, as in amoebiasis, developed any diarrhea; and in the cases in which diarrhea was part of the original illness, as in some cases of amoebiasis, the diarrhea promptly ceased on initiation of Tetracycline treatment.

Two patients also reported slight nausea. One of these was in the group who also reported slight alteration of his bowel habits.

One patient reported slight anal pruritus, of short duration.

No other ill effects of the drug were noted.

## SUMMARY

At the time of writing no clinical reports have appeared in the general literature, concerning the gastrointestinal side-effects of a new broad spectrum antibiotic (Tetracycline). In 100 cases treated in private practice, of a wide range of acute infections, one case developed definite diarrhea, and six others noted temporary slight looseness of the stools, in a frequency of only one to three stools per day. It appears from this preliminary study that Tetracycline therapy is accompanied by a very low incidence of intestinal side-effects, at the same time retaining the broad spectrum effect of similar antibiotics.\*\*

\* Generously supplied by Dr. Stanton Hardy of Lederle Laboratories, as Achromycin, the trademark of Lederle Company for the antibiotic Tetracycline. \*Chlorotetracycline, the trademark of Lederle Company for Aureomycin. \*Oxytetracycline, the trademark of Pfizer Company for Terramycin.

† South Bend Clinic, South Bend, Indiana.

\*\* Since this report was written, the author has treated an additional 272 cases with even less side-effects. Of the total of 372 cases, there have been 14 cases of moderate or slight looseness of stools, but only the one frank diarrhea. There have been six reports of nausea, three of anal pruritus, and one questionable slight rash.

# The *Journal*

of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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## A REPORT AND AN INVITATION TO THE MEMBERS

**D**URING THE PAST TWO YEARS numerous changes have been made in the format of THE JOURNAL. A new cover design, larger type face, and improvement of layout have all served to modernize its appearance and improve its readability. The policy in regard to number of illustrations has been liberalized in order to provide adequate illustration for the scientific articles and to furnish pictures of interest for the news items.

While these physical changes were taking place the editorial staff has been pleased to find that the number of top-notch scientific articles submitted for publication has increased. During the past few years our scientific pages have been recognized by other medical publications in the form of an increasing number of abstracted articles in other journals and in year books.

One of the things that has made improvement

possible is the enlargement of the editorial staff. The Council of the I.S.M.A., under whose direction THE JOURNAL is published, takes an active interest in its affairs. Two years ago the number of associate editors was increased from one to four. This year the new members of the Editorial Board were selected during the summer so that they could participate in staff meetings before taking office.

Another asset which has contributed to the success of THE JOURNAL is the widespread interest which is taken in it by its thousands of readers. The members of the Indiana State Medical Association and their loyalty to it is probably the greatest asset THE JOURNAL has. This aspect of THE JOURNAL's operation becomes more apparent each year. The willingness of many physicians of the state to assist in an unofficial way, the graciousness with which many have responded to requests for scientific articles, the numerous constructive suggestions and the

general overall body of goodwill which THE JOURNAL enjoys among its readers, have all aided in its improvement.

THE JOURNAL staff wishes to foster this state of affairs and take full advantage of it. During the Annual Convention it is planned to have a small meeting place in or near the lounge room of the Murat Temple. A cordial invitation is extended to all members to drop by and talk

about THE JOURNAL, or stay a while and settle any other important matters which may need discussion.

The staff will welcome criticism or suggestions. We all regard our publication as a joint effort,—one in which all members of the Association may be joined for our mutual benefit. We would like for Hoosier doctors to feel that they are all on the Editorial Board.

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### BLINDNESS SHOULD BE REPORTED

ACCORDING to state law the State Board of Health is required to maintain a register of all blind persons in the state. The law places the responsibility for reporting such cases on the practicing physicians. The reportable cases include not only those who are totally blind, but also those whose impairment of vision is sufficient to interfere with their ability to make a living. Persons of all ages, including infants and children, are to be reported.

The Department of Health has circularized

the county medical societies of the state, in order that all physicians will be informed of the provisions of the law. Many of the activities of the School for the Blind and of the Board of Industrial Aid and Vocational Rehabilitation for the Blind are planned to disseminate information which will be of public health interest to the blind, and it is for this reason that a complete file of names is important.

A special card form, blue in color, is furnished by the local health officer, or by the Division of Vital Records, State Board of Health.

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### REAP NEW BENEFITS (?) UNDER SOCIALISM

HERE is a new angle to Britain's socialized medicine scheme. Under the British health service, patients now have discovered they can sue the government if they do not get well. Under the legal aid scheme, which is a separate Socialist institution, they can even get the government to furnish them a free lawyer to handle their suit. Furthermore, if they win, the government pays off. If they lose, the court costs still have to be paid by the government.

"So have a go. It's all on the welfare state,"

writes London correspondent Ernie Hill in the Chicago Daily News. He reports that a rash of lawsuits against hospitals under the National Health Service has broken out all over the place, with medical authorities estimating that some 200 suits for damages have been filed in the last three years. It would seem that there is never a dull moment in the welfare state. We wonder what happens to the doctor who fails to get the patient well.

—The Journal of the Florida  
Medical Association





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*minimal*

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*side*

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*effects*

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**ACHR**

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One of the notable qualities of ACHROMYCIN, the Lederle brand of Tetracycline, is its advantage of minimal side effects. Furthermore, this true broad-spectrum antibiotic is well-tolerated by all age groups.

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\*REG. U.S. PAT. OFF

# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

The summer is over, and we hope that every Indiana doctor has had his share of care-free and restful vacation. I know of no one who needs it more!

But there are other good times in store for you profession-wise, as well as much useful knowledge to be gained, at the Annual Indiana State Medical Convention on October 25, 26 and 27. We hope you are, even now, making your plans, and your hotel reservations, to be in Indianapolis for those days, and that you will bring your wife with you! When you register, be sure to buy her tickets for the luncheon and dinner meetings which have been planned for her. Our general chairman, Mrs. Lester Bibler of Indianapolis, and her committee, have been working for months to arrange an interesting program for her, and insure her a good time. Our National President-elect, Mrs. Mason G. Lawson, Little Rock, Arkansas, will be with us and speak at our luncheon. The dinner meeting will be in honor of our past presidents. If she plays golf, there is provision made for her special enjoyment on the 27th. She is also invited to attend, with or without her husband, the three splendid evening programs which have been prepared for your enjoyment by the Indiana State Medical Association.

If your wife is a state officer, state committee chairman, or county president or president-elect, her presence will be urgently needed at the semi-annual Board Meeting which will be convened at 10:00 a.m. at the Athletic Club, Tuesday, October 26. All other Auxiliary members are cordially invited to attend this meeting, even though they have no vote.

Let's make this the biggest convention ever!

November, and national elections are almost upon us! We hope all Auxiliary members are already studying the various candidates and are intelligently making up their minds for what, and whom, they will vote. Many of our county Auxiliaries have entered into the campaign to "Get out the vote". We hope that all Indiana doctors will get up a little early on election morning, or squeeze in time to vote before that baby case is ready, or before the hour that important surgery is scheduled. Be sure to remind your wife to vote (or vice versa) and encourage her to invite some friends to go along. Even though this is not a Presidential year, the Congressional majority is *very close*, and the local issues are also important. We can't afford to let down our guard now!

The Indiana State Medical Association very kindly allowed us to put up a display for Today's Health in its booth at the State Fair. Mrs. Paul Sparks, Winchester, our State Chairman, writes me that when the material from the National office of Today's Health arrived, it turned out to be a TRUCK LOAD! There must have been 3,000 sample copies of the magazine! Mrs. George T. Paulissen, Marion County Today's Health Chairman, who had charge of setting this material up, was completely floored! (Who wouldn't have been?) Where to have it unloaded, or how to move it later, she didn't know! But, a phone call to Mr. Waggener, our ever helpful adviser, solved the difficulty, and everything turned out all right. Those sample copies should sell lots of subscriptions.

That reminds me—don't forget to visit our Today's Health booth at the Murat Temple and give your own and a couple of gift subscriptions to the Auxiliary member in charge! Only \$1.50 per year for the professional man! Your own county Auxiliary will get the credit.

The State Auxiliary appreciates this space which is allotted to us each month. We hope it will create a better understanding of our work and purposes.

Mrs. Harry C. Harvey, President



# The President's Page

Fellow Members of I.S.M.A.:

THIS issue of the Journal and the fall meeting of the Indiana State Medical Association will wind up my year as President of your organization. I am very grateful for the honor you have given me. I have been interested in organized medicine for many years, first on the county level, and for the last 12 years on the state level. This takes a lot of time away from your practice and family. If I have made any worth-while addition to the practice of medicine I feel it has been worth the work and sacrifice. Probably someone else could have done it better, and undoubtedly will in the future, but the work still has to be done.

When you read the reports of the deliberations of your organization for the last 105 years, you are impressed with the advances that have occurred in medicine. When you learn how the early Doctors of Medicine had little formal training, received most of their knowledge from preceptors and by the school of hard knocks, you appreciate the part your society has played in advancing medical education and improving the standards of those men and women who practice the art. Most of the legislation and the weeding out of the charlatans has been at the insistence of organized medicine.

In recent years the insurance principle has been applied to medical care. This has leveled out the cost, and has allowed many people to receive adequate care who otherwise could not have afforded it. It has also allowed the people to use the doctor of their own choice which is so essential to good medicine. The practice of medicine can never be purely mechanical, the fears and background of the patient can only be evaluated by the physician who truly knows his patient and is really interested in his welfare. In England today many of the labor unions are negotiating for an insurance program that will allow the patient to employ his own physician in contrast to the panel physician who sees the hundred or more a day under the present system.

At the present time there is a program in progress trying to raise the standards in our hospitals. This is very worthwhile but let's not get ourselves so specialized that the average doctor has no place to work and must refer his cases to a colleague who is on the staff of the hospital, thus the family doctor cannot truly follow the case. We must guard against the hospital taking over the practice of medicine instead of it being a place to treat our patients better. Recently one of our Indiana hospitals was deferred as being ineligible for intern training because it did not have an out-patient department. The men in the city explained that this type of work was being done by the local men in their offices. They felt that to establish a pre-natal clinic and an out-patient department would not improve the care of their patients. The Council on Medical Care and Hospitals said the interns needed this training. This may be resolved by taking the interns into their local offices for short periods to do some of this type of work. Again we do not want to force the hospitals into the practice of medicine.

In closing I want to say that I have thoroughly enjoyed my work with our organization. I have made many friends and met a great many people in Indiana and the surrounding states that I would never have met had I not been associated with this group. Like the old fire horse who was put out to pasture, I will enjoy the rest but will probably snort and run when the fire whistle blows.

*Wm Harry Howard M.D.*

# Indianapolis VA Hospital "Bureaucracy"

ED KLINGLER\*

*Evansville*

**A**N EVANSVILLE veteran, crippled for life by a World War II injury, propelled his wheelchair up to the admitting desk at the Indianapolis Veterans Administration Hospital.

His wants were simple: A checkup on his condition.

As a veteran injured while in the service of his country he was entitled to all the medical or surgical care he needed. Had he been a veteran with an ailment not connected with his military service, or acquired since the war, he could have received medical attention by making a statement that he had no resources to pay for it in a private institution.

Here's what the Evansville veteran said happened to him:

"The receiving clerk mistakenly thought mine was a non-service case. He filled out my admission application himself. Without asking me if I could afford private care he also filled out the pauper statement.

"The two veterans just ahead of me had come to the hospital for treatment not connected with their military service. The receiving clerk never bothered to ask them if they could afford care in private hospitals—he just filled out their pauper statements."

The Evansville veteran has been in and out of hospitals ever since his injury. He knows how long it takes for that checkup. It takes three days, and he actually doesn't have to be in the hospital.

At Indianapolis he was required to take a hospital bed. And he was there two weeks to take the tests requiring only three days.

He complained about the loss of time. He

was told: "We're simply overloaded. We're processing your checkup just as fast as we can."

Overloaded with what? The hospital doctors, most of whom are consultants from private hospitals, didn't know—they aren't required to know. They're only responsible for the care of the patients.

The Evansville veteran asked a hospital executive: "How many of your patients are here for treatment for service-connected ailments?" The executive didn't know. He said they were all veterans so far as he was concerned. He finally ventured the guess, however, that perhaps a third of those in the hospital were suffering from service-connected ailments.

The Evansville veteran asked one of the consulting physicians if he had any idea how many of the patients he was treating in his particular specialty had service-connected ailments. The physician said: "I'd say about one per cent."

One per cent to 33 per cent is a wide disparity. The Evansville veteran polled the 24 men in the section of the ward he occupied. He was the only one of the 24 in the hospital for a service-connected ailment.

"In fact," he says, "during my two weeks in that hospital I was the only service-connected patient I had knowledge of. There probably were others—I failed to find them."

One of the patients he queried had developed a tumor in the leg.

He had gone to a private physician in Indianapolis who had recommended its immediate removal. It would cost around \$500. In spite of the fact he was perfectly capable of paying \$500, he decided to get it for nothing at the Veterans Hospital.

Says the Evansville veteran: "This patient was admitted to a room, although he was per-

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\* Mr Klingler is on the staff of the Evansville Press. This column on VA hospital policies and administration has attracted widespread attention.

fectly able to be up and around—and was. He occupied that room for a month before they got around to performing the operation.”

The Evansville veteran calls the Veterans Administration hospital program a “political bureaucracy,” and, he says, “it isn’t any joke.”

“During the remainder of my life I am going to need considerable medical attention if I am to maintain my health and productiveness,” he says. (He has an important position.) “Up to now I have taken care of more than 90 per cent of the cost myself because I can’t afford to give up the time to go to a Veterans Hospital to get attention I know from experience requires only a few hours.

“Not only myself, but thousands of veterans with genuine service-connected disabilities, which entitle us to free care under the VA are faced with a real problem.

“We must take our turn among the many more thousands who are chiseling on the program with the connivance of the Veterans Administration.”

He considers it an irony that those who need the care and are entitled to it, those for whom the VA hospitals were built, are handicapped by

the political aspects of the program and actually get less care than they’re entitled to.

The story doesn’t end there.

The Evansville veteran has a paraplegic friend whose wheelchair wore out. He applied to the Veterans Administration for a new one. He didn’t get it. What he got instead was a long letter of explanation why he couldn’t have it. The Veterans Administration had gone beyond its budget—it was broke. Later, perhaps. So the veteran for whom the veterans protective laws were written went without a wheelchair while the veterans hospitals were loaded up with non-service connected cases getting a free ride at government expense.

Says the Evansville veteran: “The American Legion cries to high Heaven when any move is made to correct the situation. I have reluctantly reached the conclusion the American Medical Association is right.

“The A.M.A. has been publicly lamenting this situation for years, and has received no reward but criticism. It charges the Veterans Hospital program is being abused. The A.M.A. calls it creeping Socialism. The A.M.A. is too mild, it’s worse than that.”

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#### QUOTES:

**AUTOMOBILE INJURIES.** The possibility of abdominal injuries which could cause death should be investigated in all cases of automobile accidents, it was stated in the Archives of Surgery, published by the American Medical Association. The automobile, it added, is one of the leading sources of civilian injury, with multiple injuries commonplace.

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**A GOOD SLEEP.** Fear of not getting enough sleep, drilled into an individual from childhood, can keep an individual awake nights, according to an article in the A.M.A.’s Today’s Health magazine.

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**SAFETY PINS.** Removal of an open safety pin from the throat of a five-week-old baby, the youngest infant on record to swallow an open safety pin, was reported recently by the American Medical Association.

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**POLIO RECOVERY.** Psychological, emotional, educational and vocational guidance is just as important as medical treatment in effecting recovery from poliomyelitis, it was stated in the A.M.A. American Journal of Diseases of Children.



# CONVENTION NOTES



Literally, there'll be something to please everyone at the 1954 Annual Convention of Indiana State Medical Association!

\* \* \*

An innovation this year will be the streamlined format of the Scientific Sessions—symposiums on many topics will be moderated by authorities in their fields and will present discussions of many sub-topics by prominent out-of-state speakers and Indiana physicians. This thought-provoking panel plan offers opportunity for discussion at all sessions.

\* \* \*

Scientific Exhibits—22 of them—will offer a visual cross-section of modern medicine's many facets.

\* \* \*

Technical Exhibits are actually bigger and better than ever—103 exhibitors will display new drugs, new equipment, new methods. Exhibitors' representatives will be ready to confer with you throughout the session on any problems you may have.

\* \* \*

Some fortunate Indiana physician who takes the time to visit each exhibit—having his exhibitors' book stamped at each booth—will drive home in a NEW 1955 STUDEBAKER REGAL COMMANDER 4-DOOR SEDAN! No strings attached! That will be the No. 1 prize. The *newly designed* Studebaker will be on display throughout the convention just outside the Exhibit Hall.

\* \* \*

Second prize to some doctor who visits all the exhibits—a \$100 merchandise certificate good in trade with any 1954 exhibitor!

\* \* \*

Third Prize—a \$50 merchandise certificate good in trade with any exhibitor!

\* \* \*

Dr. Elmer Hess, president-elect of the American Medical Association, will be headline attraction at the Annual Dinner Wednesday night, October 27, in the famous Kellersaal at the Athenaeum. If you have heard Dr. Hess—you'll be there; if you have not had that privilege, don't miss this opportunity to hear this outstanding speaker.

\* \* \*

Section meetings will be held Wednesday afternoon. Consult your program on the following pages for time and place of the meeting *you* wish to attend.

\* \* \*

Entertainment highlights of 1954 will include the inimitable Dr. Fabien Sevitzy, conductor of the Indianapolis Symphony Orchestra, with Ethel Smith, world famous organist, as guest artist. The orchestra will be composed primarily of Indianapolis Symphony personnel. Mark PRESIDENT'S NIGHT, Tuesday, on your convention calendar as a must! Dr. Wm. Harry Howard, your 1953-1954 president, will give his address preceding the musical program.

\* \* \*

Stag party guests Monday night will hear the ambitious amateurs from Lafayette—the Krusty Krumbs—in their first Indianapolis appearance. A musical aggregation of doctors, dentists, accountants, (the minister moved away) they are reported to have a high rating for entertainment . . . and music.

(Continued on Page 1122)

105th  
Annual Convention

# INDIANA STATE MEDICAL ASSOCIATION

October 25, 26 and 27, 1954

Murat Temple

Indianapolis

*Complete Program and  
Annual Reports on  
Following Pages*

# Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Indiana, October 24, 25, 26 and 27, 1954.

The House of Delegates will be constituted as follows: Marion County, eighteen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jasper-Newton, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other fifty-nine county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, R. L. Sen-senich, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Carl H. McCaskey, N. K. Forster, Cleon A. Nafe, Augustus P. Hauss, C. S. Black, Alfred Ellison, J. William Wright, and Paul D. Crimm; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 6:30 p.m., Sunday, October 24, in the Indiana University Student Union Building, Indianapolis (dinner meeting), and again at 7:30 a.m., Wednesday, October 27, in the Kellersaal, Athenaeum. (breakfast meeting).

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Address of president-elect.
6. Report of executive secretary.
7. Report of treasurer.
8. Report of the chairman of the Council.
9. Reports of councilors.

## 10. Reports of standing and special committees:

- (1) Executive Committee.
- (2) Board of Appeals on Patient-Physician Relations.
- (3) County Medical Society Officers' Conference.
- (4) Constitution and By-Laws.
- (5) Convention Arrangements.
- (6) Industrial Health.
- (7) Medical Education and Hospitals.
- (8) Public Policy and Legislation.
- (9) Public Relations.
- (10) Publicity.
- (11) Rural Health.
- (12) Subcommittee on Preceptorships.
- (13) Scientific Exhibits.
- (14) Scientific Work.
- (15) Alcoholics Study.
- (16) Anti-National Health Insurance.
- (17) Auditing.
- (18) Cancer.
- (19) Chronic Illness.
- (20) Civil Defense.
- (21) Conservation of Vision.
- (22) Crippled Children Services.
- (23) Diabetes.
- (24) Hard of Hearing.
- (25) Heart Disease.
- (26) Indiana Inter-Professional Health Council.
- (27) Instructional Courses.
- (28) Maternal and Child Health.
- (29) Medical Care Insurance.
- (30) Mental Health.
- (31) Military Manpower.
- (32) Necrology.
- (33) Physician-Hospital Relationship.
- (34) School Health and Physical Education.
- (35) State Fair.
- (36) Traffic Safety.
- (37) Tuberculosis.
- (38) Venereal Disease.
- (39) Veterans Affairs and Rehabilitation.
- (40) Liaison Committee with the Indiana Association of Licensed Nursing Homes.
- (41) Liaison Committee with Labor.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the



terms of the following officers expire December 31, 1954, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Cleon A. Nafe, Indianapolis, and E. S. Jones, Hammond; and alternates, Earl W. Mericle, Indianapolis, and William C. Wright, Fort Wayne.

Delegates from the second, fifth, eighth and eleventh districts are reminded that the terms of their councilors will expire December 31, 1954, and

the new councilors should be elected to succeed the following:

Second District: Arthur G. Blazey, Washington.

Fifth District: M. C. Topping, Terre Haute.

Eighth District: T. R. Hayes, Muncie.

Eleventh District: Elton R. Clarke, Kokomo.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER,  
*Executive Secretary*

# HOUSE OF DELEGATES

## Indiana State Medical Association

Indianapolis—October 24-27, 1954

Delegates	Alternates	Delegates	Alternates
<b>ADAMS</b>		<b>DUBOIS</b>	
James M. Burk, Decatur	Gerald J. Kohne, Decatur		
<b>ALLEN</b>		<b>ELKHART</b>	
W. C. Wright, Fort Wayne	R. C. Stauffer, Fort Wayne		
R. N. Kent, Fort Wayne	D. S. Painter, Fort Wayne	Burton Kintner, Elkhart	F. S. Martin, Goshen
E. C. Singer, Fort Wayne	C. H. Somers, Fort Wayne	<b>FAYETTE-FRANKLIN</b>	
<b>BARTHOLOMEW-BROWN</b>		Albert F. Gregg,	F. B. Mountain,
L. F. Beggs, Columbus	H. E. Rothring, Columbus	Connersville	Connersville
Kenneth D. Schneider,		H. N. Smith, Brookville	Perry Seal, Brookville
Nashville		<b>FLOYD</b>	
<b>BENTON</b>		John M. Paris,	Kenneth Brown,
V. L. Turley, Fowler	A. L. Coddens, Earl Park	New Albany	New Albany
<b>BOONE</b>		<b>FOUNTAIN-WARREN</b>	
C. G. Kern, Lebanon	Jack Porter, Lebanon	Lee J. Maris, Attica	Lowell R. Stephens,
<b>CARROLL</b>		James W. Crain,	Covington
James R. McLaughlin,	Charles Wise, Camden	Williamsport	Carl A. Nelson,
Flora			West Lebanon
<b>CASS</b>		<b>FULTON</b>	
Earl B. Jewell,	Lowell Hillis, Logansport	John C. Glackman, Sr.,	Charles Richardson,
Logansport		Rochester	Rochester
<b>CLARK</b>		<b>GIBSON</b>	
Ralph Bruner,	H. H. Reeder	James F. Peck, Princeton	Virgil McCarty, Princeton
Jeffersonville	Jeffersonville	<b>GRANT</b>	
<b>CLAY</b>		Robert Brown, Marion	Henry Alderfer, Marion
John Palm, Brazil	Robert K. Webster,	<b>GREENE</b>	
	Brazil	Sam Rotman, Jasonville	J. A. Graf, Bloomfield
<b>CLINTON</b>		<b>HAMILTON</b>	
Frank Beardsley,	John Beardsley,	Robert Harris, Noblesville	Haldon Kraft,
Frankfort	Frankfort		Noblesville
<b>DAVIESS-MARTIN</b>		<b>HANCOCK</b>	
Robert Rang, Washington	Philip Fox, Washington	D. D. Gill, Greenfield	Robert W. Kuhn,
Francis Gootee, Loogootee			Wilkinson
<b>DEARBORN-OHIO</b>		<b>HARRISON-CRAWFORD</b>	
J. M. Pfeifer,		William E. Amy, Corydon	Carl E. Dillman, Corydon
Lawrenceburg		Claude A. Davis, Milltown	
G. S. Fessler, Rising Sun		<b>HENDRICKS</b>	
<b>DECATUR</b>		O. T. Scamahorn, Pittsboro	J. C. Stafford, Plainfield
D. D. Dickson, Greensburg		<b>HENRY</b>	
<b>DE KALB</b>		W. M. Stout, New Castle	L. C. Marshall, Mt. Summit
C. I. Weirich, Butler	H. V. Hippensteele,	<b>HOWARD</b>	
	Auburn	R. P. Good, Kokomo	Robert Evans, Russiaville
<b>DELAWARE-BLACKFORD</b>		<b>HUNTINGTON</b>	
Clay A. Ball, Muncie		G. M. Nie, Huntington	R. D. Meiser, Huntington
Kemper Venis, Muncie			
Edward F. Wierzalis,			
Hartford City			

Delegates		Alternates		Delegates		Alternates	
JACKSON				Ralph V. Everly, Indianapolis		Lowell I. Thomas, Indianapolis	
Jack E. Shields, Brownstown				Bernard D. Rosenak, Indianapolis		Richard M. Nay, Indianapolis	
JASPER-NEWTON							
W. G. Pippenger, Brook				MARSHALL			
Jack L. Titus, Rensselaer				A. A. Thompson, Tyner			
JAY				MIAMI			
Stanley M. Hammond, Portland				O. B. Johnson, Peru			
Donald E. Spahr, Portland				S. D. Malouf, Peru			
JEFFERSON-SWITZERLAND							
Robert Zink, Madison				J. M. Kirtley, Crawfordsville			
A. P. Petway, Madison				F. N. Daugherty, Crawfordsville			
JENNINGS							
D. W. Matthews, North Vernon				Ray Miller, Martinsville			
Benet W. Thayer, North Vernon				John Van Wienen, Martinsville			
JOHNSON							
William D. Province, Franklin				J. R. Nash, Albion			
Joseph Ferrara, Franklin				Ivan A. Clark, Paoli			
KNOX							
Herbert O. Chattin, Vincennes				V. C. McMahan, Vincennes			
KOSCIUSKO							
LA GRANGE				PARKE-VERMILLION			
Philip Yunker, Howe				H. B. Pirkle, Rockville			
Kenneth Lehman, Topeka				Fred Evans, Clinton			
LAKE							
R. J. Modjeski, Hammond				Donald L. Lashley, Tell City			
J. P. Vye, Gary				M. H. Omstead, Petersburg			
J. B. Nicosia, East Chicago				Ralph C. Eades, Valparaiso			
J. P. Birdzell, Crown Point				W. B. Challman, Mt. Vernon			
H. R. Stimson, Gary				H. J. Halleck, Winamac			
Ray Elledge, Hammond				V. Earle Wiseman, Greencastle			
LA PORTE							
G. O. Larson, LaPorte				Richard M. Potter, Ridgeville			
Victor F. Kling, Michigan City				W. C. McConnell, Sunman			
Thomas D. Armstrong, Michigan City				George S. Row, Osgood			
LAWRENCE							
Lawrence E. Benham, Bedford				Frank Green, Rushville			
William R. Noe, Bedford				Robert B. Johnson, Rushville			
MADISON							
G. B. Wilder, Anderson				F. R. N. Carter, South Bend			
Ralph Ploughe, Elwood				D. D. Stiver, South Bend			
S. W. Ellis, Anderson				W. D. Buchanan, South Bend			
MARION							
D. S. Megenhardt, Indianapolis				Donald Grillo, South Bend			
Earl W. Mericle, Indianapolis				Carl Bogardus, Austin			
Paul Merrell, Indianapolis				Paul R. Tindall, Shelbyville			
Kenneth E. Thornburg, Indianapolis				Michael Monar, Rockport			
William M. Browning, Indianapolis				J. C. Glackman, Jr., Rockport			
R. A. Solomon, Indianapolis				J. M. McIntyre, Indianapolis			
O. W. Sicks, Indianapolis				Albert M. Donato, Indianapolis			
Glen V. Ryan, Indianapolis				Roy A. Geider, Indianapolis			
John E. Owen, Indianapolis				J. M. McIntyre, Indianapolis			
Harry R. Kerr, Indianapolis				Joe Dukes, Dugger			
Don J. Wolfram, Indianapolis				C. E. Whipps, Carlisle			
Harold C. Ochsner, Indianapolis							
John W. Hendricks, Indianapolis							
Loren H. Martin, Indianapolis							
Lawson J. Clark, Indianapolis							
James W. Denny, Indianapolis							

Delegates	Alternates	Delegates	Alternates
<b>TIPPECANOE</b>		<b>WHITLEY</b>	
Gordon A. Thomas, Lafayette	M. J. Eaton, Lafayette	Thomas G. Hamilton, Columbia City	Otto Lehmberg, Columbia City
W. W. Washburn, Lafayette	R. B. DuBois, Lafayette		
<b>TIPTON</b>		<b>COUNCILORS</b>	
A. E. Stouder, Kempton	Meredith B. Gossard, Tipton	1st District—Minor Miller, Evansville	
<b>VANDERBURGH</b>		2nd District—Arthur G. Blazey, Washington	
Charles P. Schneider, Evansville	John E. Alexander, Evansville	3rd District—William H. Garner, New Albany	
Henry J. Rusche, Evansville	Daniel C. Tweedall, Evansville	4th District—Joseph E. Dudding, Hope	
E. L. Fitzsimmons, Evansville	L. Edward Gaul, Evansville	5th District—M. C. Topping, Terre Haute	
C. C. Herzer, Evansville		6th District—W. U. Kennedy, New Castle	
		7th District—Lester D. Bibler, Indianapolis	
		8th District—T. R. Hayes, Muncie	
		9th District—Wemple Dodds, Crawfordsville	
		10th District—J. R. Doty, Gary	
		11th District—Elton R. Clarke, Kokomo	
		12th District—Maurice E. Glock, Fort Wayne	
		13th District—Kenneth L. Olson, South Bend	
<b>VIGO</b>		<b>PAST PRESIDENTS</b>	
Hubert T. Goodman, Terre Haute	A. W. Cavins, Terre Haute	Charles S. Bond, Richmond	
Ernest Nay, Terre Haute	Wm. C. Kunkler, Terre Haute	William H. Stemm, North Vernon	
		E. M. Shanklin, Hammond	
		Charles N. Combs, Terre Haute	
		George R. Daniels, Marion	
		Charles E. Gillespie, Seymour	
		R. L. Sensenich, South Bend	
		Herman M. Baker, Evansville	
		Karl R. Ruddell, Indianapolis	
		M. A. Austin, Anderson	
		C. H. McCaskey, Indianapolis	
		N. K. Forster, Pacific Palisades, Calif.	
		Cleon A. Nafe, Indianapolis	
		A. P. Hauss, New Albany	
		C. S. Black, Warren	
		Alfred Ellison, South Bend	
		J. William Wright, Indianapolis	
		Paul D. Crimm, Sidney, Ohio	
<b>WABASH</b>			
R. M. LaSalle, Wabash	George Seward, North Manchester		
<b>WARRICK</b>			
W. C. Stover, Boonville	Peter B. Hoover, Boonville		
<b>WASHINGTON</b>			
I. E. Huckleberry, Salem	A. R. Episcopo, Salem		
<b>WAYNE-UNION</b>			
Glen Ward Lee, Richmond	Tom Shields, Richmond		
James F. Lewis, Liberty	Fred Shepard, College Corner, Ohio		
<b>WELLS</b>			
Truman E. Caylor, Bluffton	Homer B. Annis, Bluffton		
<b>WHITE</b>			
S. E. McClure, Monon	N. A. Hibner, Monticello		

## CONVENTION ARRANGEMENTS

**CONVENTION ARRANGEMENTS:** R. M. Hansell, chairman; James M. Leffel, Harry Pandolfo, Hugh K. Thatcher, Jr., and William E. Sutton, all of Indianapolis.

**HOUSING:** Chairman, J. E. Gillespie.

**GOLF:** Chairman, J. M. McIntyre.

**TRAP SHOOT:** Chairman, H. M. Banks.

**WOMEN PHYSICIANS:** Chairman, Olga Bonke Booher; Jane M. Ketcham, Helen D. VanVactor.

**RECEPTION:** Chairman, Russell J. Spivey, and past presidents of the Indianapolis Medical Society.

**ENTERTAINMENT:** Chairman, James M. Leffel.

**PUBLICITY:** Chairman, Harry Pandolfo.

**WOMEN'S ENTERTAINMENT:** Chairman, Mrs. Lester D. Bibler.

**FIFTY YEAR CLUB RECEPTION:** Chairman, Leonard A. Ensminger.



## REFERENCE COMMITTEES—1954

## ANNUAL CONVENTION—October 25, 26 and 27

**1. Sections and Section Work:**

Harold C. Ochsner, Indianapolis (Marion),  
chairman  
Lester D. Bibler, Indianapolis (Marion)  
William C. McConnell, Sunman (Ripley)  
Elmer C. Singer, Fort Wayne (Allen)  
James F. Peck, Princeton (Gibson)

**2. Rules and Orders of Business:**

A. P. Hauss, New Albany (Floyd), chairman  
Frank Green, Rushville (Rush)  
Ralph C. Eades, Valparaiso (Porter)  
V. L. Turley, Fowler (Benton)  
Will W. Washburn, Lafayette (Tippecanoe)

**3. Medical Education and Hospitals:**

G. O. Larson, LaPorte (LaPorte), chairman  
D. D. Dickson, Greensburg (Decatur)  
G. B. Wilder, Anderson (Madison)  
C. G. Kern, Lebanon (Boone)  
Glen V. Ryan, Indianapolis (Marion)

**4. Legislation:**

Ray Elledge, Hammond (Lake), chairman  
Lawson J. Clark, Indianapolis (Marion)  
F. R. N. Carter, South Bend (St. Joseph)  
John Owen, Indianapolis (Marion)  
Joseph E. Dudding, Hope (Bartholomew-Brown)

**5. Public Relations:**

W. U. Kennedy, New Castle (Henry), chairman  
William C. Reed, Bloomington (Owen-Monroe)  
J. P. Vye, Gary (Lake)  
Milton H. Omstead, Petersburg (Pike)  
Hubert T. Goodman, Terre Haute (Vigo)

**6. Hygiene and Public Health:**

J. William Wright, Sr., Indianapolis (Marion),  
chairman  
Clay A. Ball, Muncie (Delaware-Blackford)

Truman E. Caylor, Bluffton (Wells)  
V. Earle Wiseman, Greencastle (Putnam)  
W. G. Pippenger, Brook (Jasper-Newton)

**7. Amendments to the Constitution and By-Laws:**

T. R. Hayes, Muncie (Delaware-Blackford),  
chairman  
Alfred Ellison, South Bend (St. Joseph)  
Robert H. Rang, Washington (Daviess-Martin)  
G. S. Fessler, Rising Sun (Dearborn-Ohio)  
Raymond J. Modjeski, Hammond (Lake)

**8. Reports of Officers:**

J. R. Doty, Gary (Lake), chairman  
C. S. Black, Warren (Huntington)  
Earl W. Mericle, Indianapolis (Marion)  
Minor Miller, Evansville (Vanderburgh)  
John M. Paris, New Albany (Floyd)

**9. Credentials:**

W. C. Stover, Boonville (Warrick), chairman  
Glen Ward Lee, Richmond (Wayne-Union)  
D. D. Stiver, South Bend (St. Joseph)  
Sam Rotman, Jasonville (Greene)  
Paul R. Tindall, Shelbyville (Shelby)

**10. Insurance:**

H. R. Stimson, Gary (Lake), chairman  
J. W. Denny, Indianapolis (Marion)  
Elton R. Clarke, Kokomo (Howard)  
M. C. Topping, Terre Haute (Vigo)  
E. L. Fitzsimmons, Evansville (Vanderburgh)

**11. Miscellaneous Business:**

William H. Garner, New Albany (Floyd),  
chairman  
Cleon A. Nafe, Indianapolis (Marion)  
Maurice E. Glock, Fort Wayne (Allen)  
Kenneth L. Olson, South Bend (St. Joseph)  
John Palm, Brazil (Clay)

1953 - 1954

## Officers of the I. S. M. A.



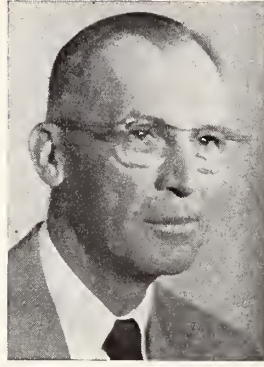
WM. HARRY HOWARD, M.D.

Hammond

PRESIDENT  
INDIANA STATE MEDICAL ASSOCIATION  
1953-1954



W. L. PORTEUS, M.D.  
President-Elect  
Franklin



ROY V. MYERS, M.D.  
Treasurer  
Indianapolis



JAMES A. WAGGENER  
Executive Secretary  
Franklin



ELTON R. CLARKE, M.D.  
Chairman of Council  
Kokomo



JAMES W. DENNY, M.D.  
Chairman, Executive  
Committee  
Indianapolis



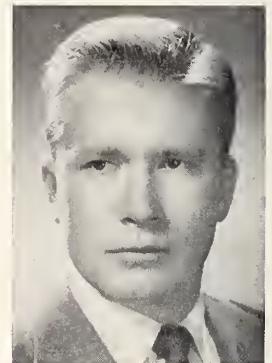
E. H. CLAUSER, M.D.  
Executive Committee  
Muncie



MRS. HARRY C. HARVEY  
President, Auxiliary  
Fort Wayne



ROBERT J. AMICK  
Field Secretary  
Scottsburg



KENNETH W. BUSH  
Field Secretary  
Indianapolis





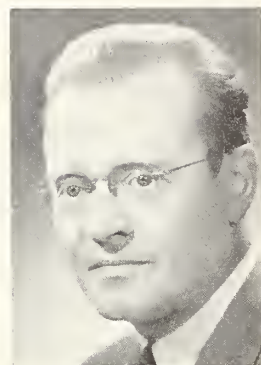
**E. M. SHANKLIN**  
Editor Emeritus  
THE JOURNAL  
Hammond



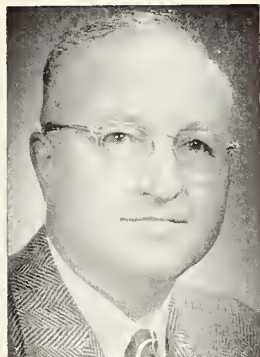
**FRANK B. RAMSEY**  
Editor  
THE JOURNAL  
Indianapolis



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Associate Editor  
Terre Haute



**L. G. MONTGOMERY**  
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**DAVID A. BICKEL**  
Associate Editor  
South Bend



**STEPHEN L. JOHNSON**  
Associate Editor  
Evansville



**RICHARD H. MILLER**  
Editorial Board  
Fort Wayne



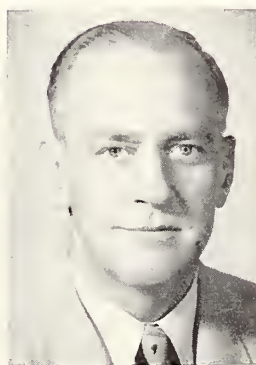
**George M. Cook**  
Editorial Board  
Hammond



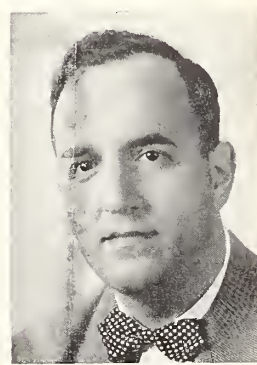
**C. S. CULBERTSON**  
Editorial Board  
South Bend



**HAROLD D. LYNCH**  
Editorial Board  
Evansville



**SAMUEL R. MERCER**  
Editorial Board  
Fort Wayne

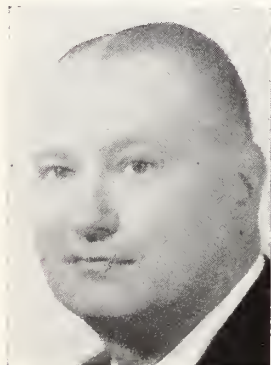


**GEORGE N. LEWIS**  
Editorial Board  
Gary

# Section Officers

## Surgery

### CHAIRMEN



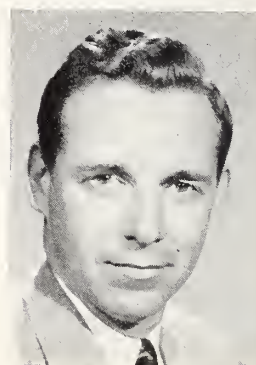
THOMAS C. HALLER  
Crawfordsville

### VICE-CHAIRMEN



TRUMAN E. CAYLOR  
Bluffton

### SECRETARIES



JOSEPH B. DAVIS  
Marion

## Medicine



PAUL L. STIER  
Fort Wayne



JACK L. EISAMAN  
Bluffton



RICHARD S. GRIFFITH  
Indianapolis

## Ophthalmology and Otolaryngology



J. WILLIAM WRIGHT, JR.  
Indianapolis



HERSCHEL SMITH  
Bloomington

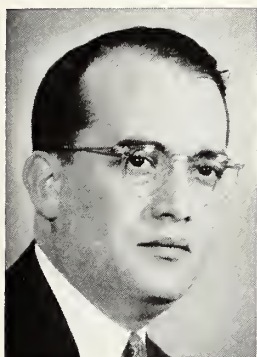


M. RICHARD HARDING  
Indianapolis



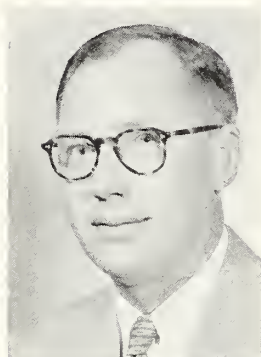
## Anesthesiology

### CHAIRMEN



MEREDITH B. FLANIGAN  
Indianapolis

### VICE-CHAIRMEN



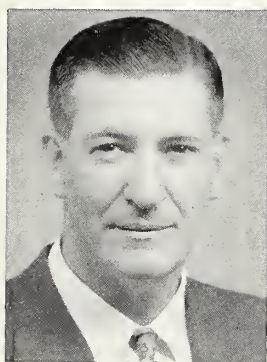
EMORY D. HAMILTON  
Fort Wayne

### SECRETARIES

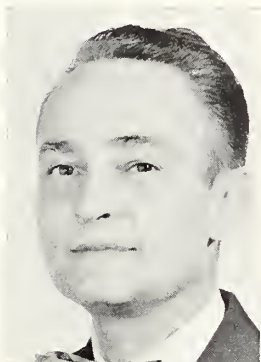


V. K. STOELTING  
Indianapolis

## General Practice



NORMAN R. BOOHER  
Indianapolis



FRANK H. GREEN, JR.  
Rushville

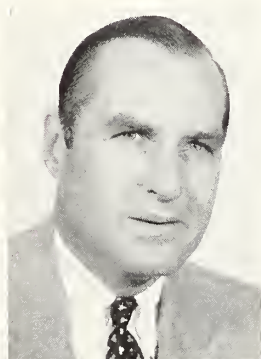


RUSSELL J. SPIVEY  
Indianapolis

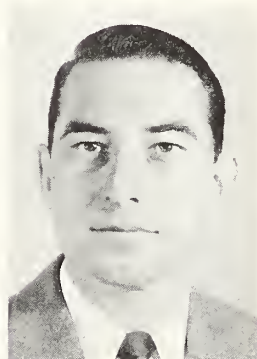
## Obstetrics and Gynecology



PIERCE MacKENZIE  
Evansville



SPRAGUE H. GARDINER  
Indianapolis



FRANCIS G. STOUT  
Muncie



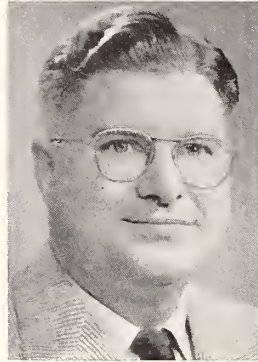
## Public Health and Preventive Medicine

### CHAIRMAN



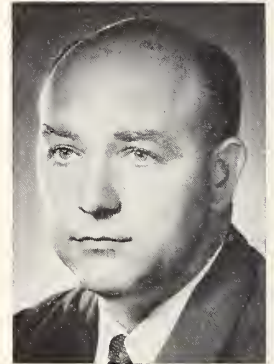
MINOR MILLER  
Evansville

### VICE-CHAIRMAN



L. L. RENBARGER  
Marion

### SECRETARY



WILSON L. DALTON  
Shelbyville

## Convention Notes

(Continued)



"KRUSTY KRUMS"

Monday night's entertainment headliner in the Murat Theater will be Mr. Mystery—the Miraculous Mentalist. He gives an impelling, amazing performance of mental wizardry—he will fascinate you as blindfolded, he tells you objects on your person and where you got them, your Social Security number, serial numbers on money in YOUR pocket. The Chicago Tribune calls him the "Human Lie Detector"—you'll be baffled, too!

\* \* \*

At the Annual Dinner Wednesday night special recognition will be given Dr. Charles S. Bond of Richmond who was President of Indiana State Medical Association in 1894-1895. Dr. Bond hopes to be present for this momentous occasion.

\* \* \*

Physicians who are model railroaders will have their own show at convention. This may be the nucleus of a real hobby show in future years.

\* \* \*

From opening time Monday morning until the convention closes Wednesday night every Indiana physician attending may be reached by calling the EMERGENCY NUMBER—MElrose 4-1461, Indianapolis. An attendant will be on hand at all times. Be sure to give this telephone number to your office assistant and your home before coming to Indianapolis if you wish to be reached without delay.

# PROGRAM

105th Annual Convention—1954

INDIANA STATE MEDICAL ASSOCIATION

Murat Temple, Indianapolis

## Sunday, October 24

- 12:00 Executive Committee meeting, Indiana University Student Union Building.
- 3:00 Council meeting, Indiana University Student Union Building.
- 6:30 Meeting of House of Delegates, Indiana University Student Union Building. (Dinner meeting.)
- Invocation.

## Monday Evening

- 6:00 Reception and annual dinner meeting for women physicians, Indianapolis Athletic Club. (Dinner at 6:30.)
- 7:00 Buffet supper, smoker and stag party, Dining Room, Murat Temple.
- 9:15 Entertainment for physicians, their wives, and guests, Murat Theater. Mr. Mystery.

## Monday Morning October 25

- 8:00 Registration starts, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.
- 8:30 Opening of technical and scientific exhibits, lounge room, Murat Temple.
- 9:00 Reference Committees meet. See bulletin board for exact time and place.
- 10:00 Annual golf tournament. Banker's handicap, Meridian Hills Country Club.
- 10:00 Annual trap shoot, Indiana Gun Club.
- 11:00 Editorial Board meeting, Directors' Room, Athenaeum. (Luncheon meeting.)
- 11:00 Instructional courses, Murat Temple.

Mac Murray—the "Mr. Mystery" of show business will present a one-man show Monday night. Featured by Robert Ripley in "Believe It or Not", Mac Murray is confounding more people each year. He works rapidly, offering an entertaining and amazing program.



"Mr. Mystery"

## Monday Afternoon

- 1-5 Instructional courses, Murat Temple.
- 2-4 Reference Committees meet. See bulletin board for exact time and place.

## Tuesday Morning October 26

- 7:30 Breakfast meeting of Committee on Industrial Health, Circle Room, Columbia Club.
- 8:00 Registration continues, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.
- 8:30 Technical and scientific exhibits, lounge room, Murat Temple.
- 8:30 Scientific movies, Murat Theater.

## GENERAL MEETING

(Murat Theater)

- 9:30 Call to order by Wm. Harry Howard, M.D., Hammond, president. Indiana State Medical Association.

Greetings by Russell J. Spivey, M.D., president, Indianapolis Medical Society, and Robert M. Hansell, M.D., Indianapolis, chairman of Committee on Convention Arrangements.

Welcome, Alex M. Clark, Mayor, City of Indianapolis.

- 9:35 "Medical and Surgical Emergencies."—a symposium.

Chairman: JAMES O. RITCHEY, M.D., Indianapolis.

(Each speaker limited to 10 minutes for presentation)



Ritchey

JAMES O. RITCHEY, M.D., Indianapolis. Professor and chairman, Department of Medicine, Indiana University School of Medicine; specialist in internal medicine. Graduate I. U. School of Medicine, 1918. Governor for Indiana, American College of Physicians.

Participants:

"Surgical Emergencies."

R. ARNOLD GRISWOLD, M.D., Louisville, Kentucky.



Griswold

R. ARNOLD GRISWOLD, M.D., Louisville. Professor of surgery, University of Louisville; in private surgical practice. Native of Peru, Indiana; attended Harvard University and received medical degree in 1925 at the University of Louisville School of Medicine.

"Pediatric Emergencies."

WILLIAM C. VANCE, M.D., Richmond, Indiana.

WILLIAM C. VANCE, M.D., Richmond. Board certified pediatrician in private practice. Native of Illinois; graduate in 1934 of Indiana University School of Medicine; internship and residency at Indiana University Medical Center.



Vance

"General Practice Emergencies."

GEORGE L. THORPE, M.D., Wichita, Kansas.



Thorpe

GEORGE L. THORPE, M.D., Wichita, Kansas. President, Kansas Academy of General Practice, 1951; in private practice. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, in 1938. Served as flight surgeon Mediterranean area; on teaching staffs Wichita hospitals.

"Medical Emergencies."

HARVEY C. KNOWLES, JR., M.D., Cincinnati.

HARVEY C. KNOWLES, JR., M.D., Cincinnati. Assistant professor of medicine, University of Cincinnati College of Medicine since 1952; graduate of Yale University and Columbia University College of Physicians and Surgeons, 1942; military service 1943-1946; staff Cincinnati General Hospital, 1946-1950.



Knowles

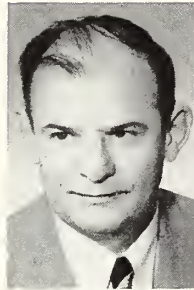


## Tuesday Morning—Contd.)

*"Anesthesia Emergencies."*

PAUL H. LORHAN, M.D., Kansas City, Kansas.

PAUL H. LORHAN, M.D., Kansas City, Kansas. Clinical professor of anesthesiology and chairman of the department, University of Kansas School of Medicine; consultant in anesthesiology, Wadsworth Veterans and VA Hospitals, Kansas City. Native of Pennsylvania; graduate Creighton University School of Medicine, 1935.



Lorhan

*"Orthopedic Emergencies."*

JOSEPH C. LAWRENCE, M.D., Evansville.



Lawrence

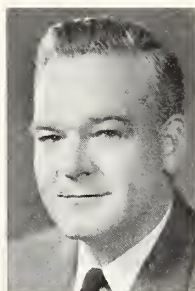
JOSEPH C. LAWRENCE, M.D., Evansville. Orthopedic surgeon in private practice. Native Nebraskan; 1933 graduate University of Nebraska School of Medicine. Special training in orthopedics at Cleveland Clinic and Shriners Hospital for Crippled Children, Shreveport, Louisiana. Served as Chief of Orthopedic Section, 107th Station Hospital, New Britain and Luzon, and 7th Evacuation Hospital, Japan.

## QUESTION AND ANSWER PERIOD

11:00 *"The Role of the General Practitioner in Industrial Medicine."*

GEORGE F. WILKINS, M.D., Professor of Industrial Medicine, Harvard Medical School, Boston.

GEORGE F. WILKINS, M.D., Boston, Massachusetts. Instructor in surgery Harvard Medical School and lecturer in industrial medicine, Harvard School of Public Health; medical director New England Telephone and Telegraph Company. Native of Kinderhook, New York; graduate of Harvard Medical School, 1932. President, Industrial Medical Association 1953-54. Served as lieutenant-colonel Army Medical Corps 1942 through 1945.



Wilkins

11:30 *"Industrial Backs."*

FREMONT A. CHANDLER, M.D., Professor of Orthopedic Surgery, University of Illinois College of Medicine, Chicago.

FREMONT A. CHANDLER, M.D., Chicago. Professor and director, Orthopedic Department, University of Illinois College of Medicine; in private practice as orthopedic surgeon, Chicago. Graduate of Columbia Medical School, New York, 1919; past president American Orthopaedic Association.



Chandler

## Tuesday Noon October 26

12:00 Luncheon meeting of Committee on Mental Health, rear of Palm Room, Athenaeum.

12:00 Luncheon meeting of examiners for Civil Aeronautics Association and members of Aero Medical Association, Veterans Room, Athenaeum.

12:00 Luncheon meeting of Indiana Association of Pathologists, Ladies Parlors, Athenaeum.

12:00 Luncheon meeting and reunion of Class of 1903, Medical College of Indiana, Directors' Room, Athenaeum. (Oldest class holding reunion)

12:00 Phi Beta Pi luncheon, East Room, Athenaeum.

12:00 Phi Rho Sigma luncheon, Kneipe Room, Murat Temple.

12:15 Luncheon meeting of members of State and County Tuberculosis Committees, Fraternity Room, Athenaeum. Indiana Chapter of American College of Chest Physicians and Trudeau Society participating.

Business meeting.

Speaker: ANDREW C. OFFUTT, M.D., Indianapolis, State Health Commissioner

Subject: *"Management of Recalcitrant Tuberculosis Patients."* X-ray conference. (Please bring your interesting films)

ANDREW C. OFFUTT, M.D., Indianapolis. Health commissioner of Indiana and secretary of the Indiana State Board of Health. Native of Indiana; graduate I. U. School of Medicine, 1940, and veteran of 10 years' army service. Served as director of Bureau of Preventive Medicine three years before assuming present post.



Offutt

12:15 Luncheon, State Trauma Committee, Indiana Chapter, American College of Surgeons, Keller-saal, Athenaeum.

# GENERAL MEETING

## Tuesday Afternoon October 26

(Murat Theater)

2:00 "Newer Developments in Medicine."—panel discussion.

(Each speaker limited to 10 minutes for presentation)

Moderator: KENNETH G. KOHLSTAEDT, M.D., Indianapolis.



Kohlstaedt

KENNETH G. KOHLSTAEDT, M.D., Indianapolis. Professor of medicine, Indiana University School of Medicine, and director, Clinical Research Division, Eli Lilly and Company. Native of Indianapolis; graduate I. U. Medical School, 1932. Specializes in clinical research.

Participants:

"Evaluation of Pentothal Curare and Other New Anesthetics."

PAUL H. LORHAN, M.D., Kansas City, Kansas.

"Poliovirus Vaccines."

CLYDE G. CULBERTSON, M.D., Indianapolis.

CLYDE G. CULBERTSON, M.D., Indianapolis. Professor of clinical pathology, Indiana University School of Medicine, and director of biological research at Lilly Research Laboratories, Indianapolis. Received medical degree from I. U. in 1931; specializes in clinical pathology.



Culbertson

"Surgery."

R. ARNOLD GRISWOLD, M.D., Louisville, Kentucky.

"The Use of Radioisotopes in the Treatment of Pelvic Malignancy."

ALLAN C. BARNES, M.D., Professor of Obstetrics and Gynecology, Western Reserve University, The School of Medicine, Cleveland, Ohio.



Barnes

ALLAN C. BARNES, M.D., Cleveland. Arthur H. Bill professor of obstetrics and gynecology and chairman of the department, Western Reserve University School of Medicine. Native of Michigan; graduate Princeton and University of Pennsylvania Medical College 1937; major U. S. Army Medical Corps, 1942-45.

"Technique of Radical Neck Dissection."

BRUCE PROCTOR, M.D., Detroit.

BRUCE PROCTOR, M.D., Detroit, Michigan. Assistant professor in otolaryngology Wayne University School of Medicine; in private practice specializing in otolaryngology. Native of Detroit and 1936 graduate University of Michigan Medical School; former instructor in otolaryngology University of Chicago Medical School.



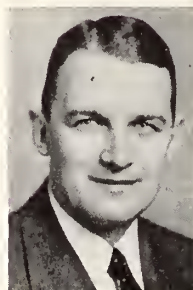
Proctor

"Modern Concepts of Lupus Erythematosus."

JOHN R. HASERICK, M.D., Cleveland.

(Brayton Foundation speaker)

JOHN R. HASERICK, M.D., Cleveland, Ohio. Staff member of the Cleveland Clinic, Department of Dermatology; winner of Hektoen Silver Medal for scientific exhibit on systemic lupus erythematosus at A. M. A. convention, 1952. Native of Minneapolis and graduate of University of Minnesota Medical School, 1941.



Haserick



*"Evaluation of the Antibiotics."*

WILLIAM W. FRYE, M.D., New Orleans.



Frye

*"Revascularization of the Myocardium for the Treatment of Coronary Artery Heart Disease."*

EMANUEL MARCUS, M.D., Hammond, Indiana.

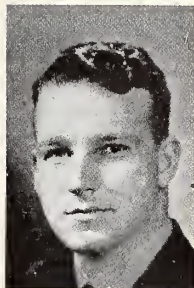
EMANUEL MARCUS, M.D., Hammond. Assistant professor of surgery, The Chicago Medical School and staff, departments of surgery and cardiovascular research, Michael Reese Hospital, Chicago. In private practice, specializing in general and thoracic surgery. Graduate Rush Medical College, 1942.



Marcus

*"Newer Drugs in Hypertension."*

JOSEPH H. HAFKENSCHIEL, M.D., Philadelphia.



Hafkenschiel

JOSEPH H. HAFKENSCHIEL, M.D., Philadelphia. Associate in medicine, and staff member, Robinette Foundation for study of cardiovascular disease, Hospital of the University of Pennsylvania. Native of Youngstown, Ohio; graduate Johns Hopkins University School of Medicine, 1941; military service 1942-1946.



Dr. Fabien Sevitzy



Ethel Smith

## Tuesday Evening October 26

(Murat Theater)

- 5:30 Exhibits close.
- 6:00 Dinner meeting and twentieth anniversary reunion of class of 1934 of Indiana University School of Medicine, Indianapolis Athletic Club.
- 8:00 President's Night, Murat Theater.  
Address: WM. HARRY HOWARD, M.D., Hammond, president.  
Entertainment: Dr. Fabien Sevitzy, Conductor of the Indianapolis Symphony Orchestra, with Ethel Smith and her Hammond organ.



## Wednesday Morning October 27

- 7:30 Final meeting of House of Delegates, Kellersaal, Athenaeum. (Breakfast meeting). Business meeting in Little Auditorium, Athenaeum. Meeting of Council immediately following adjournment of House of Delegates.
- 8:00 Registration continues, lounge room, Murat Temple.  
Purchase your banquet tickets at the registration desk.
- 8:30 Technical and scientific exhibits, lounge room, Murat Temple.
- 8:30 to  
10:00 Scientific movies, Murat Theater.
- 10:00 to  
10:30 Intermission to view technical and scientific exhibits.

## GENERAL MEETING

(Murat Theater)

- 10:30 *"Fractures of the Ankle"*

CARL L. GILLIES, M.D., Iowa City.



Gillies

CARL L. GILLIES, M.D., Iowa City, Iowa. Professor of Radiology, State University of Iowa College of Medicine. Born in Hamilton, Michigan; received medical degree, University of Michigan, 1926.

11:00 to

### 12:00 MEDICO-LEGAL ECONOMIC SESSION

- 11:00 *"Why Does Our Government Compete with Its Taxpayers?"*

JOSEPH F. LEOPOLD, Dallas, Texas.

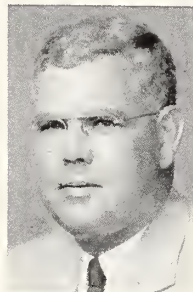
JOSEPH F. LEOPOLD, Dallas, Texas. Speaks for National Associated Businessmen, Inc. of Washington, D. C. Public and industrial relations counsel; former manager, Iowa State Chamber of Commerce; southern-central division manager, United States Chamber of Commerce; attorney; lecturer on economics.



Leopold

- 11:30 *Report of State of Indiana Commission on Alcoholism*

FRED E. LAWRENCE, M.D., Indianapolis.



Lawrence

FRED E. LAWRENCE, M.D., Indianapolis. Medical director of the Indiana Commission on Alcoholism. Native of Miami, Florida; received medical degree, Washington University at St. Louis, 1944; two years military service. In private practice and on staffs of Taunton, Massachusetts State Hospital and University of Missouri before assuming present post.

## Wednesday Noon October 27

- 12:00 Luncheon meeting of Section on Obstetrics and Gynecology, East Room, Athenaeum.

- 12:00 Luncheon meeting, Indiana Roentgen Society, Ladies Parlors, Athenaeum.

Speaker: CARL L. GILLIES, M.D., Iowa City.

Subject: *"Mediastinal Tumors."*

- 12:00 Luncheon meeting of Medical Appointees of the Indiana Bell Telephone Company, Blue Room, Athenaeum.

Informal discussion of common problems.

- 12:00 Luncheon meeting of Officers and Directors, Indiana Academy of General Practice, Directors' Room, Athenaeum.

- 12:15 Nu Sigma Nu, Alumni luncheon, Fraternity Room, Athenaeum.

- 12:30 Phi Chi luncheon, Veterans Room, Athenaeum.

- 12:30 Luncheon meeting of Class of 1921, Indiana University School of Medicine, Columbia Club.

# Wednesday Afternoon

## October 27

2:00 Conference on Civil Defense, Egyptian Foyer.

Glen Ward Lee, M.D., Richmond, Chairman,  
Committee on Civil Defense, presiding.

### "Civil Defense"

JOHN M. WHITNEY, M.D., Battle Creek,  
Michigan



Whitney

JOHN M. WHITNEY, M.D., Battle Creek, Michigan. Director, Casualty Care Division, Federal Civil Defense Administration. Native of Mississippi; medical degree from Tulane University School of Medicine, 1934. Former Red Cross medical director, eastern area; now commissioned by U. S. PHS.

2:20 "Ophthalmology's Stake in Systemic Disease."

EDWIN W. DYAR, M.D., Indianapolis.



Dyar

EDWIN W. DYAR, JR., M.D., Indianapolis. Professor of ophthalmology at Indiana University School of Medicine. Board certified specialist in private practice. Graduate of I. U. School of Medicine, 1930.

2:40 "Experiences of an Isotope Committee."

STEPHEN L. JOHNSON, M.D., Evansville.

STEPHEN L. JOHNSON, M.D., Evansville. Board certified specialist in internal medicine; in private practice. Received medical degree Indiana University School of Medicine, 1933; in military service three years. Chief of medical service, St. Mary's Hospital and internist member Isotopes Committee, Protestant Deaconess Hospital.



Johnson

3:00 "The Use and Abuse of Bone Marrow Biopsy."

LOUIS A. SCHNEIDER, M.D., Fort Wayne.



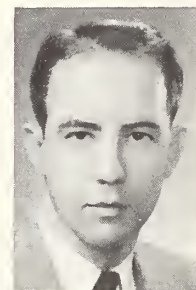
Schneider

LOUIS A. SCHNEIDER, M.D., Fort Wayne. Associate director of laboratories and associate pathologist, St. Joseph's Hospital; medical director Red Cross regional blood center. Born New York City; graduate New York University College of Medicine, 1940; U. S. Army Medical Corps, 1942-1946.

3:20 "Vectorcardiography."

CHARLES E. JACKSON, M.D., Bluffton.

CHARLES E. JACKSON, M.D., Bluffton. Member internal medicine staff, Caylor-Nickel Clinic and Hospital since 1951. Native of Bluffton; received medical degree, I. U. School of Medicine, 1946. Instructor, Army Medical Department Research and Graduate School, Washington, D. C., 1947-49, and instructor in medicine, Tulane University, 1949-1951.



Jackson

3:40 Discussion period.

4:30 Election of section officers for 1955.

## SECTION MEETINGS

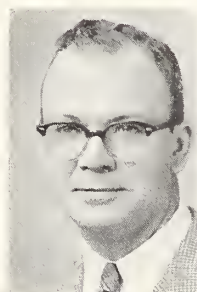
### MEDICINE

(Murat Theater)

2:00 "Spastic Colon Syndrome."

FRANK M. THOMPSON, M.D., Columbia City.

FRANK M. THOMPSON, M.D., Columbia City. Chief of department of internal medicine, Lin-vill Memorial Clinic. Born in Tanta, Egypt; graduate of Western Reserve University School of Medicine, Cleveland, 1937.



Thompson

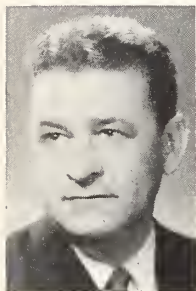
# SURGERY

(Murat Candidates Room)

## SURGERY OF INFANTS AND CHILDREN

2:00 *"The Orthopedic Aspect with Special Reference to Open Reduction of Certain Fractures."*

NORMAN F. RICHARD, M.D., Shelbyville.



Richard

NORMAN F. RICHARD, M.D., Shelbyville. General surgery, Inlow Clinic. Native of Fort Wayne; graduate of Indiana University School of Medicine, 1938; served 1942-46 with Army Portable Surgical Hospital in China-Burma-India theater.

2:15 *"Inguinal Hernia."*

PIERRE C. TALBERT, M.D., Bluffton.

PIERRE C. TALBERT, M.D., Bluffton. General surgery, Caylor-Nickel Clinic and Hospital. Born in Auburn, Indiana; graduate of Indiana University School of Medicine, 1944.



Talbert

2:30 *"Congenital Hypertrophic Pyloric Stenosis."*

CLEON M. SCHAUWECKER, M.D., Greencastle.



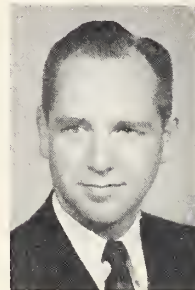
Schauwecker

C. M. SCHAUWECKER, M.D., Greencastle. In private practice, specializing in general surgery; Board certified. Native of Clay City, Indiana; received medical degree Indiana University School of Medicine, 1942.

2:45 *"Appendicitis in Infancy and Childhood."*

RICHARD M. DAVIS, M.D., Marion.

RICHARD M. DAVIS, M.D., Marion. Specialist in general surgery and orthopedics at Davis Clinic; first assistant to Dr. Charles W. Mayo, Mayo Clinic, 1950-1951. Native of Marion; medical degree, Indiana University, 1944; captain, USA, and chief of orthopedics and assistant chief of general surgery, Rodriguez General Hospital, San Juan, Puerto Rico, 1946-1948.



Davis

3:00 *"Management of Congenital Obstructions of the Small Intestine."*

RICHARD R. HUGHES, M.D., Lafayette.



Hughes

RICHARD R. HUGHES, M.D., Lafayette. Board certified specialist in general surgery; in private practice. Born in Indianapolis; graduate of Indiana University School of Medicine, 1942; on staffs St. Elizabeth and Home hospitals.

3:15 *"Surgical Treatment of Thoracic Lesions in Children."*

J. S. BATTERSBY, M.D., Indianapolis.

J. STANLEY BATTERSBY, M.D., Indianapolis. Associate professor of surgery, Indiana University School of Medicine. Native of Lake County, Indiana; 1939 graduate of I. U. School of Medicine; Board certified specialist in surgery.



Battersby

3:30 Discussion of all papers.

4:00 Election of section officers for 1955.

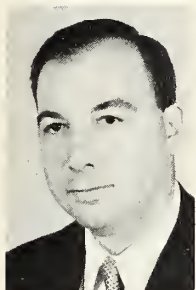


## OPHTHALMOLOGY AND OTOLARYNGOLOGY

(Basement Lounge)

2:00 *"Eye Manifestations of Intracranial Aneurysms."*

MORTIMER MANN, M.D., Indianapolis.



Mann

MORTIMER MANN, M.D., Indianapolis. Associate professor, Indiana University School of Medicine; in private practice in ophthalmology and otolaryngology. Native of New York City and graduate of New York Medical College, 1937.

2:30 *"Esophageal Obstruction and Swallowing Difficulties."*

HERBERT A. LAUTZ, M.D., Hammond.

HERBERT A. LAUTZ, M.D., Hammond. Specialist in private practice in otolaryngology; Board certified. Born in Newfane, New York; graduate of University of Rochester School of Medicine, 1945.



Lautz

3:00 *"Corneal Transplants and Wound Healing."*

MARVIN CUTHBERT, M.D., Indianapolis.



Cuthbert

MARVIN CUTHBERT, M.D., Indianapolis. Associate professor in ophthalmology, Indiana University School of Medicine; in private practice in ophthalmology. Graduate of I. U. School of Medicine, 1937.

3:30 *"The Surgical Anatomy of the Neck."*

BRUCE PROCTOR, M.D., Detroit.

4:00 Election of section officers for 1955.

## GENERAL PRACTICE

(Egyptian Room)

2:00 *"Modern Office Therapeutics."*

GEORGE L. THORPE, M.D., Wichita, Kansas.

3:00 *"The Problems Facing Family Physicians Today."*

JOHN S. DeTAR, M.D., Milan, Michigan.

JOHN S. DeTAR, M.D., Milan, Michigan. Michigan's "Family Physician of 1948" began the study of medicine at 26. He had graduated from college and established himself in the real estate business in Detroit. With a family to support he worked and attended school 22 hours a day. He practices on a similar schedule.



DeTar

4:00 Business meeting and election of section officers for 1955.

## OBSTETRICS AND GYNECOLOGY

(East Room, Athenaeum)

12:00 Luncheon meeting.

Moderator: ALLAN C. BARNES, M.D., Cleveland, Ohio.

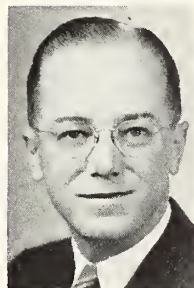
Dr. Barnes will develop each subject for 15 to 20 minutes, followed by five-minute discussions.

1:00 *"Hypotensive Drugs in the Toxemias of Pregnancy."*

Discussion:

FLOYD T. ROMBERGER, M.D., Indianapolis.

KENNETH G. KOHLSTAEDT, M.D., Indianapolis.



Romberger

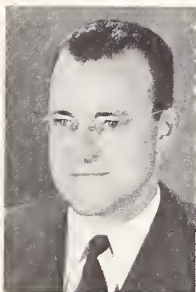
FLOYD T. ROMBERGER, M.D., Indianapolis. Instructor in obstetrics and gynecology, Indiana University School of Medicine; in private practice, specializing in obstetrics and gynecology. Native of Pennsylvania and 1937 graduate of Indiana University School of Medicine.

## 2:00 "Obstetrical Anesthesia."

## Discussion:

CARROLL W. HASEWINKEL, M.D., Indianapolis.

MURWYN L. HICKS, M.D., Indianapolis.



Hasewinkel

CARROLL W. HASEWINKEL, M.D., Indianapolis. Member anesthesia staff, Methodist Hospital; Board certified. Born in West Salem, Illinois; graduate of Indiana University School of Medicine, 1941.

M. L. HICKS, M.D., Indianapolis. Instructor in anesthesiology, Indiana University School of Medicine. Native of New Market, Iowa; received medical degree from State University of Iowa, College of Medicine, 1944.



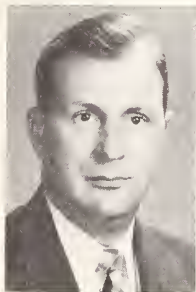
Hicks

## 3:00 "Leukorrhea and Pruritis Vulvae."

## Discussion:

PAUL F. MULLER, M.D., Indianapolis.

L. HOWARD ALLEN, M.D., Bedford.



Muller

PAUL F. MULLER, M.D., Indianapolis. Assistant professor in obstetrics and gynecology, Indiana University School of Medicine; chief of obstetrical and gynecological section. St. Vincent's Hospital; graduate of St. Louis University School of Medicine, 1940; specialty training at the New York Lying-In Hospital.

LONIEL HOWARD ALLEN, M.D., Bedford. Specialist in obstetrics and gynecology; in private practice; Board certified. Obtained medical degree from Indiana University School of Medicine, 1926. Major and flight surgeon, 1942-1946.



Allen

4:00 Election of section officers for 1955.

## PUBLIC HEALTH AND PREVENTIVE MEDICINE

(Little Auditorium, Athenaeum)

## 2:00 "The Role of Antibiotics in the Treatment of Intestinal Parasitism."

WILLIAM W. FRYE, M.D., New Orleans.

## 3:00 "The Health Officer Looks at the Polio Vaccine Validity Trial."—a symposium.

Moderator: MINOR MILLER, M.D., Evansville.



Miller

MINOR MILLER, M.D., Evansville. Specialist in public health and county health officer. Native of Miami county, Indiana; graduate of Indiana University School of Medicine, 1912.

## Participants:

G. W. ERICKSON, M.D., South Bend.

WALTER E. KRUSE, M.D., Fort Wayne.

IVAN J. MARKEL, M.D., Elkhart.

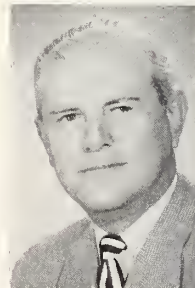
WENDELL C. ANDERSON, M.D., Indianapolis.



Erickson

G. W. ERICKSON, M.D., South Bend. Pediatrician, Board certified, at South Bend Clinic. Born in Springfield, Massachusetts; graduate, Medical College of Virginia, 1944; captain, U. S. Army Medical Corps, 1945-1947.

WALTER E. KRUSE, M.D., Fort Wayne. Health commissioner of Fort Wayne; in general practice. Native of Fort Wayne; graduate of St. Louis University School of Medicine, 1923.



Kruse



Markel

IVAN J. MARKEL, M.D., Elkhart. General surgery and county health officer. Received medical degree from Rush Medical College, Chicago, 1911.

## Wednesday Evening October 27

7:00 Annual dinner, Kellersaal, Athenaeum.

Presiding officer, WM. HARRY HOWARD, M.D., President, Indiana State Medical Association.

WENDELL C. ANDERSON, M.D., Indianapolis. Director, Division of Chronic Diseases and Gerontology, Indiana State Board of Health. Native of Mentone, Indiana; graduate of Indiana University School of Medicine, 1934; military service in Washington, D. C. and Australia.



Anderson

Recognition of Fifty-Year Club members.

Award to Physician of the Year.

Speaker: ELMER HESS, M.D., President-elect, American Medical Association, Erie, Pennsylvania.

4:00 Election of section officers for 1955.

Indiana Health Officers Association business meeting.

3:30 Exhibits close.

4:30 Reception for members of Fifty-Year Club, Palm Room, Athenaeum.

Speaker: C. WALTER (MICKEY) McCARTY, Editor, THE INDIANAPOLIS NEWS.

ELMER HESS, M.D., Erie, Pennsylvania. President-elect of the American Medical Association. Specialist in urology and editor-publisher of the quarterly, Urolog. Native of Millville, New Jersey; graduate of University of Pennsylvania School of Medicine, 1911. Has held many official posts in state, national and international medical organizations. Served with A.E.F. in France during World War I and was recipient of many honors for heroic actions.



Hess

Presentation of certificate of merit and plaque to WM. HARRY HOWARD, M.D., president, 1954, by Walter L. Porteus, M.D., president, 1955.



## WOMEN'S ENTERTAINMENT

### Monday, October 25

Mrs. Lester D. Bibler, General Chairman

8:00 Registration starts, lounge room, Murat Temple.

6:00 Dinner, honoring past presidents of the Woman's Auxiliary to the Indiana State Medical Association, Kellersaal, Athenaeum. Mrs. Harry C. Harvey, Fort Wayne, President, presiding.

8:15 Entertainment, in conjunction with the Indiana State Medical Association, Murat Theater.

Mr. Mystery.

### Tuesday, October 26

8:00 Registration continues, lounge room, Murat Temple.

10:00 Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Green Room, Indianapolis Athletic Club.

12:30 Luncheon, honoring Mrs. Mason G. Lawson, President-elect, Woman's Auxiliary to the American Medical Association, guest speaker. Ballroom, Indianapolis Athletic Club.

Fashion Show by Wm. H. Block Company.



Mrs. Lawson

8:00 Entertainment, in conjunction with the Indiana State Medical Association, Murat Theater.

Indianapolis Symphony Orchestra, featuring Ethel Smith and her Hammond organ.

### Wednesday, October 27

8:00 Registration continues, lounge room, Murat Temple.

9:00 Golfer's delight—both 18 hole and 9 hole—Meridian Hills Country Club.

12:00 Golfer's luncheon will be served, rain or shine, Meridian Hills Country Club.

— Day free to shop —

6:30 Annual dinner, in conjunction with the Indiana State Medical Association, Kellersaal, Athenaeum.

TICKETS FOR ALL EVENTS MAY BE PICKED UP AT THE REGISTRATION DESK

Notice: Convention Arrangements Committee would appreciate advance reservations.

*Clip and mail*

To: Mrs. Lester D. Bibler  
4360 No. Penn. St.,  
Indianapolis 5, Indiana

Please make ----- reservations for Dinner, October 25th

Please make ----- reservations for Luncheon, October 26th

Please make ----- reservations for Golf, October 27th

Signed \_\_\_\_\_

# Scientific Exhibits

John L. Arbogast, M.D., Indianapolis, Chairman  
 Carl S. Culbertson, M.D., South Bend  
 Harold D. Caylor, M.D., Bluffton  
 George M. Cook, M.D., Hammond  
 R. J. McQuiston, M.D., Indianapolis  
 F. T. Romberger, M.D., Indianapolis

## Exhibit

### A. Kidney Tumors

Caylor-Nickel Clinic,  
 Truman Caylor, M.D., Bluffton

This exhibit is primarily x-ray study on the procedures to differentiate masses that occur within the kidney and possibly within the perirenal fat. The exhibit consists of flat films over the kidney area followed by intravenous pyelograms, followed by the injection of low pressure perirenal air in small quantities and its subsequent dissemination by the kidney and this then in turn followed by injection of 10 to 20 ccs of about 15% diodrast into either the kidney tumor or cyst, with studies of the fluid removed from the mass in the event it is a cyst. The principle advantages of these procedures are: that they are a combination of the common urologic procedures, can be done with the material that is at hand in the ordinary urologist's office, and you may be able to very definitely differentiate between solid tumor and cyst.

### B. Fresh Frozen Gross Tissue

Indiana Association of Pathologists

Members of the Indiana Association of Pathologists will demonstrate Fresh Gross Pathology.

Specimens will be those available at the time of the Convention.

Demonstrations will be limited to those intermission periods programmed for the viewing of exhibits.

### C. Common Ano-Rectal Pathology

E. L. Fitzsimmons, M.D. and  
 Ray H. Burnikel, M.D., Evansville

Our plan is to have a number of 35 mm. color slides showing common anorectal pathology which we have seen in the office. This would include hemorrhoids, partial prolapse, complete prolapse, fistulas, fissure, pruritis ani, etc. Interspersed between the colored pictures, we have a legend telling about the next slide and the condition.

### D. Civil Defense

Glen Ward Lee, M.D., Richmond

This exhibit consists of maps and descriptions of the medical civil defense organization, and its operation in Indiana. It will also include a display of the contents of a civil defense first aid set.

### E. Improved Infant and Mortality Rates in Indiana

Indianapolis OB Association, Dr. John Spahr

The exhibit is designed to show by means of graphs and pictures the improvement in maternal mortality rates in Indiana from 88 per 10,000 live births in 1920 to 5 per 10,000 live births in 1952 with a corresponding decrease in infant deaths under one year of age from 81.8 per 1,000 live births to 26.5 in the same span of time.

Factors responsible for this improvement are demonstrated. These include better and more widespread prenatal care; more careful intrapartum attention with improved operative techniques; control of blood loss by oxytocics and transfusion; control of infection by chemotherapeutic agents and antibiotics; control of toxemia by early recognition and institution of anti-tensive regimes. Improved care of prematures with more widespread use of transfusion and antibiotics and better methods of feeding have reduced the infant mortality rates.

### F. Benign Epithelial Tumors of the Eyelids

L. Edward Gaul, M.D., Evansville

During 1952, a family residing in southern Indiana who showed lesions of multiple benign cystic epithelioma were reported in the ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY, 68:517 (Nov.) 1953, and presented as an exhibit at the Indiana State Meeting, at French Lick, October, 1953. A prominent feature of multiple benign cystic epithelioma is the distribution of lesions on the eyelids. This aroused my interest to pursue the benign lesions further, and the exhibit planned for 1954 will include various kinds with a classification of the benign epithelial tumors affecting the lids.

### G. Anatomy and Physiology External Nasal Pyramid

Carl B. Sputh, M.D., Indianapolis

This exhibit will introduce new concepts of the anatomy and physiology of the nose. There will be illustrations and transparencies. It will introduce syndromes of Returning and Ballooning of the upper lateral cartilages. The clinical use of the Nasal Index will be illustrated. The functions of the nose in sleep and rest will be explained.

### H. Indiana Heart Foundation

Charles Fisch, M.D., Indianapolis

The exhibit deals with the limitations of electrocardiography. The fact that the electrocardiogram is only a laboratory tool is emphasized. Three viewing boxes which contain drawings and electrocardiograms form the exhibit.

### I. Indiana Association for Mental Health

The exact form of the exhibit is not yet determined. It will undoubtedly include photographs illustrative of the work, posters, and literature. It may include the showing of a film if one which the Association is making is completed.

### J. Career in Medical Technology

Indiana Society of Medical Technologists and Laboratory Technicians, Inc.

The exhibit of the Indiana Society of Medical Technologists will be designed to acquaint the members of the Indiana State Medical Association with the educational preparation necessary for registered Medical Technologists. The winning poster in a contest conducted by the American Society of Medical Technologists will be displayed. It is entitled "Educated minds and trained hands." Literature will be available from the Registry of Medical Technologists concerning the curricula required for trainees, and there will be registered Medical Technologists present to answer any questions.

### K. Inhibition of Experimental Venous Thrombosis and Clinical Applications

Irwin D. Stein, M.D.

3 Panels: 1) color microphotographs of inflammatory reaction produced experimentally in veins of rabbits, comparing phenylbutazone-treated group and controls at frequent intervals from 3 to 48 hours. Striking inhibition of inflammation and size and character of clot in former group; 2) color photographs of rapid subsidence of inflammation in various types of superficial phlebitis (in varicose veins, due to chemicals or trauma, in thromboangitis obliterans) refractory to other types of treatment; 3) charts and color photographs illus-

trating method and indications for use of phenylbutazone in phlebitis.

### L. Varicose Veins

Russell W. Lamb, M.D., Indianapolis  
Employ the Handicapped

Emmett B. Lamb, M.D., Indianapolis

The surgical treatment of varicose veins will be described through the medium of illustrations.

Films and photographs will be shown of physically handicapped persons who are gainfully employed.

### M. Auto Crash Injury Research

Indiana State Police

This is a pictorial exhibit of the activities and intent of the Indiana State Police Auto Crash Injury Research program. The objective of this research is to reduce the severity of injury to automobile occupants when involved in accidents. Photographs show various stages of traffic accident investigation, wherein data is obtained for further research. Photographs also point out the vital importance of the medical report as required in this program. It is necessary to know the severity of the injury and its cause to institute corrective measures.

### N. Rehabilitation in Poliomyelitis

The National Foundation for Infantile Paralysis, Hart E. Van Riper, M.D.

The exhibit illustrates by means of slides of actual cases that teamwork is essential between medical specialists and auxiliary personnel to successfully rehabilitate the patient who has had poliomyelitis.

### O. The Committee on Medical Education and Hospitals of the Indiana State Medical Association.

### P. Indiana Academy of General Practice

The Indiana Academy of General Practice again has a booth in the exhibits of this meeting for the purpose of allowing members to contact the new Executive Secretary, Mr. Charles G. Dosch, and to get up-to-date information on the activities and service of the Academy to its members. Officers also desire to acquaint all doctors in the state of Indiana with the effort of the Academy to bring good postgraduate educational facilities to the doctors of Indiana, no matter what type of practice, through the medium of its annual two-day Scientific Session in Indianapolis and the eight Road Show one-day meetings held in various cities throughout the state during the year. Information on hospital privileges of general practitioners is available.



**Q. Preceptor Training**

Preceptorship Committee of I.S.M.A.,  
Lester D. Bibler, Chairman

The special exhibit on the Preceptorship in Undergraduate Education for General Practice is presented by the Sub-Committee on Preceptorships of the Indiana State Medical Association. This exhibit visually demonstrates the pioneer spirit of Kansas in elevating the standards of general practice and rural medicine by exposing students to successful general practitioners throughout the state during their senior year in medical school. Preceptorships are required in the senior year curriculum. A map and color photographs illustrate the scope of the program and show the students and their preceptors in action. The purpose of showing this exhibit is to encourage Preceptorship Training in our own medical school. The exhibit will be demonstrated by the following general practitioners who have participated in the program: Joseph Dudding, M.D., Hope; Harry Voyles, M.D., New Albany; Lester Bibler, M.D., Indianapolis.

**R. Laboratory Control of Antibiotic Therapy**

Indiana Association of Pathologists  
R. D. Solomon, M.D.

The exhibit will include a demonstration of several methods of determining the sensitivity or lack of it of pathogenic bacteria to the available antibiotics. The zones of inhibition about paper discs impregnated with the antibiotics, will display the tremendous differences in strain sensitivity to the various therapeutic agents. It will be shown by charts of laboratory data from actual cases and by culture dishes that even chemically related antibiotics may range from very effective to completely ineffective drugs against the same strain of bacteria. Sweeping claims of broad-spectrum effectiveness of a given antibiotic do not hold up in clinical medical practice. By means of case reports and charts of data the great value of laboratory control of antibiotic therapy in daily practice will be made abundantly clear.

**S. Magazine Exhibit**

Woman's Auxiliary, Grace Harvey, President

Advertising and selling Today's Health magazine is purely a public relations project of the A.M.A. and the I.S.M.A., which has been given to the Woman's Auxiliary to promote. We believe every doctor in Indiana should take two subscriptions, one for his office waiting room, and another for his home, or as a gift. By staffing this booth for the duration of this meeting, we hope to bring Indiana up on this

project to the place where we shall at least reach our quota, which is the number of our members.

This subject was dealt with at length on the Auxiliary "President's Page" in the September Journal.

**T. THE JOURNAL**

Indiana State Medical Association

A visual history of THE JOURNAL of the Indiana State Medical Association will be told through the display of the first copy of THE JOURNAL off the press January 15, 1908 at Fort Wayne and the last copy off the press at Indianapolis October 15, 1954. Single copies and bound volumes during the intervening years will be shown.

Progressive steps in the publication of a single issue of THE JOURNAL will be illustrated with actual materials. For purposes of comparison, suggestion and criticism copies of other state journals of a current issue also will be available. The staff of THE JOURNAL has prepared a brief questionnaire seeking comments of members of I.S.M.A. Supplies will be on hand at the exhibit to be filled out and answers will be carefully considered by the editorial staff.

A cordial invitation is extended to all members and their families, all exhibitors and guests to stop at THE JOURNAL booth. Some member of the staff will be there to answer questions and accept suggestions. Every member of I.S.M.A. owns a share in the official publication of organized medicine in Indiana—use this opportunity to attend an informal stockholders' meeting.

**U. Polio—**

Antibiotics: Their Manufacture, Use and Administration

Indiana Pharmaceutical Association

This exhibit covers the manufacture, use and administration of various antibiotics. The intimate relationship between pharmacist and physician is thus effectively demonstrated.

**V. Differential Diagnosis in Pulmonary Diseases**  
Indiana Tuberculosis Association, Inc.

The design is centered with six x-ray plates, each showing symptoms of a different pulmonary disease. Viewers are asked to try to make a diagnosis on the basis of each plate. Diagnoses can be checked by pressing appropriate buttons. If the right button is pushed, the actual case history is illuminated above the X-ray.

# Reports of Officers

## THE EXECUTIVE SECRETARY

The occasion of the annual report of the Executive Secretary possesses a value not particularly discernible unless commented upon by the occupant of that office; for in the necessity of its annual preparation not only is the secretary impelled to review for himself the work of the staff for the past year but to estimate the requirements of the year and the years ahead.

Out of every session of the House of Delegates arise new projects, new activities and indications of patterns of future trends. What may be expressed in one year as a possible problem, often develops as such, sometimes a year or several years later and at the point of its becoming crystallized the medical profession takes action upon it through the House of Delegates. A staff which is not alert to these situations is caught unprepared and is unable to implement whatever the action of the House of Delegates may be.

Your secretary reports to you now that it is his sincere belief that medicine is turning its attention to the future more than to the present. For the past several years the most immediate pressures have been upon problems of the moment but now it appears that we are giving more consideration to problems we anticipate in the future and are moving to be prepared to meet these problems once they arrive.

While this report will review some of the projects of the various committees of the Association it is not the intent of the report to go into detail concerning every activity which has been carried on. The various committee reports published and presented to the House of Delegates by the respective committees show in detail the work accomplished during the past year. However, it will be worthwhile to highlight some of the things which have been accomplished.

Your secretary is of the opinion the actions of the last House of Delegates have been carried out as requested as well as those which have been formulated by the Council and the Executive Committee and other committees of the Association.

**RECORDING LIBRARY.** Perhaps one of the most amazing advancements in the Association's activities is the recording library being developed by the Committee on Medical Education and Hospitals. There was some doubt in the minds of many about the acceptance of this venture which is an outgrowth of the telephone seminar of several years ago.

Today the Indiana State Medical Association possesses one of the most extensive libraries of scientific material to be found anywhere in the

country. The attention of many other states and individual physicians is being focused upon this library and requests are being received from throughout the United States from doctors and medical societies inquiring as to the availability of these recordings for their own use.

As a result of the resolution presented to the AMA House of Delegates, the AMA is concerning itself with the advisability of developing a similar library of the material presented during the Clinical and Annual Sessions of that organization. As a result of this investigation representatives of the American Medical Association have visited the offices of the Indiana State Medical Association to find out just how the program is operated, its uses, etc.

Currently this library is circulating between 85 and 100 recordings per month to doctors throughout Indiana. It is also encouraging to note that many of the smaller societies are using this material for the scientific portions of their society meetings.

This activity is naturally going to be some expense to the Association but it is an additional service to the membership and has every indication of proving its worth to those who have become accustomed to using it. It is hoped as time goes on the usefulness and efficiency of this department will be increased to a point where the recording loan library will be one of the most important factors from a service standpoint to the membership of this Association.

Also in the planning stage today, is a program to develop a recorded loan library for the public school system of Indiana in which doctors of medicine will be recorded, giving short talks on various health subjects which can be used for teaching purposes in our public schools. We hope that this program will be in operation by the time this House meets next year.

## PHYSICIAN PLACEMENT IN INDIANA.

About a year ago the Rural Health Committee embarked upon a program of a physicians' placement bureau which is another department in your Association which has gained national recognition for its thoroughness and type of operation. The American Medical Association has cited the Indiana Plan as one of the most outstanding in the country and has asked for samples of the material used for distribution to other states as a model plan. This in itself speaks well for your committee and your Association's farsightedness in developing a program of such wide scope.

As a partial result of this placement service it can be reported that in the first nine months of 1954, 197 new physicians became members of the



Association. During the year 1953, only 167 physicians became new members. Demand for services of this department has been great from physicians seeking locations as well as communities seeking doctors. A bulletin service has been instituted to the communities asking for physicians and is sent to them monthly listing the names of those doctors who have inquired about openings in the state, giving their addresses and the type of practice which they prefer to do, with the suggestion the community contact the physicians who sound interesting to them and invite them to their community so they may discuss the possibility of the doctor locating permanently in that community. In addition to this the list is also carried in *THE JOURNAL* as many of you have seen. While the urgent need for medical care in some communities has not been solved in the minds of some people we do believe the activities of the placement service is beginning to solve some of the problems and certainly is bringing new physician talent to the state.

As a further step in this move the Rural Health Committee this last spring invited in all the members of the senior medical class and their wives for an afternoon and evening meeting to discuss with them the possibility of their locating in rural communities and doing general practice. The turnout exceeded expectations and from the comments of those who attended the meeting was most worthwhile. You will notice in the report of the Rural Health Committee the complete program for that day and the recommendation that next year a similar program be instituted at which time both seniors and juniors be invited and in the future the activity in this area be leveled toward the junior class. I believe this has done much to enlighten many of the men, particularly those who had questions in their minds about general practice and practice in rural communities and will prove an encouraging factor to some to locate in these needy communities.

**MEDICAL FORUMS.** While several of the county societies have actively engaged in conducting medical forums the number in relation to the total state has been somewhat discouraging.

Since it is an accepted fact that good public relations can be maintained best by the individual physician and the component society in the local community, it was hoped that every society would take this opportunity to develop a program within their own community which would bring the physician and the people of his community closer together on an informal basis for a discussion of health topics. It was felt that such a program would be costly only in time spent by those conducting the program and would pay tremendous dividends, in fact more than the expenditure of any funds which the association might use toward the cause of public relations. As these medical forums develop in various counties and the results are publicized possibly the movement will grow

with many more societies using this method of developing better relationships between the community and the county medical society.

**THE JOURNAL.** Continued effort has been made to further improve *THE JOURNAL* not only from the appearance standpoint but as to readability. You have had an opportunity during the past several months to review *THE JOURNAL* and we hope that the changes have met with your approval. We are happy to report that the improvements have met with favor among the advertising clientele and the advertising income for *THE JOURNAL* has shown a tremendous increase, during the first six months of this year, over last year.

**ANNUAL CONVENTION.** Some of the results of the 1953 convention may be noted in the 1954 meeting as is evidenced by the large number of exhibitors who have come to this convention. Your secretary is happy to report that the 1953 meeting was so successful in the opinion of the exhibitors that many letters of commendation were received and space requests made for the 1955 session. Some orders are already on file for 1955. The 1954 technical exhibit is the largest in the history of the Indiana State Medical Association. Income from this meeting is at an all time high, exceeding by several thousand dollars any previous meeting. The secretary desires to call attention of the House of Delegates to this fine support on the part of the exhibitors and to express his appreciation to the members of the Association for their splendid cooperation in visiting the exhibits and making the exhibitors feel welcome and appreciated at our annual meetings. During the past two years members have been most kind to cooperate by visiting the exhibits during the convention. This courtesy and cooperation has paid off in many ways. It is the exhibitor and his participation that makes it possible for the Association to conduct such an outstanding convention without drawing heavily upon its resources. As the importance of the Indiana meeting and the participation by exhibitors increase the annual meetings of the Association can be improved continually.

**FIELD SERVICE:** Field service has now been in operation for the past year in all sections of the state and the acceptance of the service of this department has been most gratifying. In addition to assisting county medical societies in any way possible, the field secretaries have been contacting county societies to create a better liaison between the Association and the component societies and to bring them up-to-date information on organization affairs and other matters pertinent to the practice of medicine. The Council equipped these men with cameras sometime ago and they have been taking photographs of doctors at county medical society meetings. These have appeared in *THE JOURNAL* from month to month. This has certainly increased interest in *THE JOURNAL* and we believe is doing a good job of assisting physicians



to become acquainted with other doctors throughout the state.

The field service has been instrumental in assisting many of the county medical societies with their programs and in reactivating some societies which have been inactive by assisting them in obtaining films and recordings for their scientific programs and as a result has redeveloped interest in county society meetings in some areas of the state.

For the past few months the field secretaries have been cooperating with the Blue Shield Plan by participating in meetings being held for office assistants of physicians. The field secretaries have been discussing with the office girls their role in the public relations program of organized medicine, and distributing pamphlets which have been prepared by the AMA entitled, "Winning Ways with Patients".

**MEMBERSHIP.** You will note according to the report of the Executive Committee that the membership of the Indiana State Medical Association has reached an all time high. As of the first of September of 1954 the number of members of the Indiana State Medical Association had exceeded the number on file as of December 31, 1953.

This is due partly to the fact that additional physicians are coming to Indiana. We hope that the increased interest in the program of the Association has had some bearing on encouraging some men to rejoin the Association after an absence of a few years. It is entirely feasible that at the rate we are growing the membership of the Association will exceed 4,000 by the next meeting of this House of Delegates.

With the growth in membership and the growth in activities of the Association it has been necessary to increase the personnel of the staff by the addition of another girl.

During the past year the executive secretary has been appointed a member of the Public Relations Advisory Committee of the American Medical Association and was elected secretary of the National Conference of Presidents and Officers of State Medical Associations.

It is the intention of the staff of your Association at all times to be of service to the members and component societies. It is the feeling of your staff that everything possible should be done to increase the services and usefulness of the Association office to the membership. Your staff will welcome suggestions at any time as to what further improvements could be made to increase services.

The staff would like at this time to extend an invitation to all members of the Association to spend a few minutes in the headquarters office

any time they are in Indianapolis. We would also like to remind every member that the entire staff is at your service at any time.

JAMES A. WAGGENER,  
*Executive Secretary*

## TREASURER'S REPORT

The three U. S. Treasury Certificates of Indebtedness, Series B, for \$10,000.00 each, which were purchased June 1, 1953, matured June 1, 1954. This \$30,000.00 was reinvested in U. S. Savings Bonds, Series K, earning 2.76% and maturing in twelve years. This is the only change made in investments during the year, the total investments remaining the same as listed in the accountant's report as of December 31, 1953, i. e.:

General Fund .....	\$166,000.00
Medical Defense Fund .....	19,000.00
	<hr/>
	\$185,000.00

The bank balances in the General Fund, Medical Defense Fund, The Journal and Petty Cash Funds, as of July 15, 1954, may be found in the report of the Auditing Committee.

Following is a detailed report prepared by Geo. S. Olive & Company of Indianapolis, showing the financial status of the association as of December 31, 1953.

ROY V. MYERS, M.D., *Treasurer.*

January 20, 1954

The Council,  
Indiana State Medical Association,  
Indianapolis, Indiana.

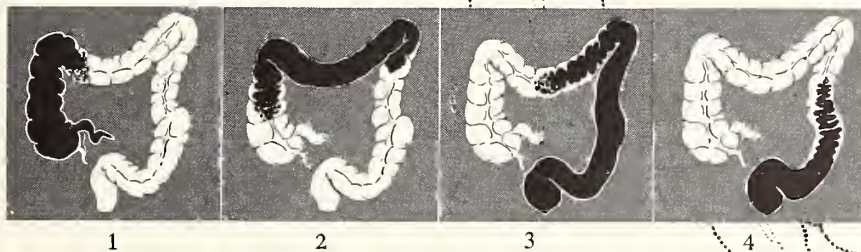
Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1953, and the statements of income and expense and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on a cash receipts and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1953, and the results of its operations for the year then

*Roentgenographic pattern of colon mass propulsion:*<sup>1</sup>

- (1) Ascending colon filled.
- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
- (4) Pelvic colon reservoir filled.



## Reestablishing Bowel Reflexes with Metamucil®

*Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.*<sup>2</sup>

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of *Plantago ovata*) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

### *Factors Contributing to Chronic Constipation*

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.<sup>2</sup>

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass

after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

### *Dosage Considerations*

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bergen, J. A.: *A Method of Improving Function of the Bowel*, *Gastroenterology* 13:275 (Oct.) 1949.

ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

GEO. S. OLIVE & Co.

Certified Public Accountants

#### Exhibit A

#### INDIANA STATE MEDICAL ASSOCIATION

##### Analysis of Increase in Assets, All Funds,

Year Ended December 31, 1953

**TOTAL ASSETS, DECEMBER 31, 1953—ex-**  
**bibit B** ----- \$216,625.20  
**TOTAL ASSETS, JANUARY 1, 1953** ----- 174,728.37  
**NET INCREASE** ----- \$ 41,896.85

Arising from the following sources:

Excess of operating cash receipts over operating cash disbursements, year ended December 31, 1953:  
 General fund—exhibit C:  
 Receipts --- \$129,346.05

Disburse-  
 ments --- 178,193.24

(48,847.19)

Add: Pur-  
 chase of  
 securities— 90,000.00

\$11,152.81

The Journal of  
 the Indiana  
 State Medi-  
 cal Associa-  
 tion — ex-  
 hibit D:  
 Receipts --- 41,139.28  
 Disburse-  
 ments --- 42,337.79

(1,198.51)

Medical De-  
 fense fund—  
 exhibit E:  
 Receipts --- 4,880.10  
 Disburse-  
 ments --- 2,937.57

1,942.53

**NET INCREASE** ----- \$ 41,896.83

#### Exhibit B

#### INDIANA STATE MEDICAL ASSOCIATION

##### State of Assets, All Funds, at December 31, 1953

#### GENERAL FUND:

Cash on deposit—Exhibit C -- \$20,602.36  
 Petty cash fund ----- 1,000.00

#### Investments:

U. S. Treasury  
 bonds ----- \$95,000.00

U. S. Savings  
 bonds ----- 71,000.00

166,000.00

Total General fund----- \$87,602.36

#### THE JOURNAL OF THE INDI- ANA STATE MEDICAL AS- SOCIATION:

Cash on deposit—Exhibit D-- 3,761.96

#### MEDICAL DEFENSE FUND:

Cash on deposit—Exhibit E-- 6,230.88

#### Investments:

U. S. Treasury  
 bonds ----- 5,000.00

U. S. Savings  
 bonds ----- 14,000.00

19,000.00

Total Medical Defense fund 25,260.88

**TOTAL ASSETS, ALL FUNDS—Exhibit A** \$216,625.20

#### Exhibit C

#### INDIANA STATE MEDICAL ASSOCIATION

##### Comparative Statement of Cash Receipts and Dis- bursements, Year Ended December 31, 1953, and December 31, 1952

#### GENERAL FUND

	Dec. 31, 1953	Year Ended Dec. 31, 1952	Increase (Decrease)
<b>CASH BALANCE</b>			
<b>AT</b>			
<b>BEGINNING OF</b>			
<b>YEAR</b> -----	\$ 69,449.55	\$ 40,715.55	\$ 28,734.00
<b>RECEIPTS:</b>			
Membership dues	115,287.00	115,850.00	( 563.00)
Income from			
exhibits -----	10,700.00	14,316.00	( 3,616.00)
Interest income ---	2,975.05	1,507.50	1,467.55
Egbert Scholar- ship fund -----		100.00	( 100.00)
Centennial book fund -----		2.50	( 2.50)
Instructional courses -----	384.00	689.34	( 305.34)
Transferred from The Journal of the Indiana State Medical Associa- tion -----		10,000.00	(10,000.00)
Total receipts —Exhibit A --	129,346.05	142,465.34	(13,119.29)

#### BEGINNING BAL- ANCE PLUS CASH

**RECEIPTS** ----- 198,795.60 183,180.89 15,614.71

#### DISBURSEMENTS:

Transfer of appli-  
 cable portion of  
 dues to The Jour-  
 nal of the Indiana  
 State Medical As-  
 sociation exhibit  
 D ----- 11,199.00 11,019.00 180.00  
 Medical Defense  
 fund—Exhibit E-- 4,387.50 4,348.75 38.75  
 Purchase of  
 securities ----- 90,000.00 35,000.00 55,000.00  
 Premium on pur-  
 chase of securi-  
 ties ----- 196.76 ----- 196.76  
 Headquarters  
 office expense -- 35,722.53 26,726.12 8,996.41



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Publicity committee -----	779.35	906.88	( 127.53)
Public policy -----	4,145.39	1,608.29	2,537.10
Council -----	1,544.18	1,480.84	63.34
Officers -----	2,961.02	2,712.09	248.93
Annual session ---	10,426.49	13,164.98	( 2,738.49)
Standing committees -----	5,380.54	5,957.07	( 576.53)
Special committees -----	3,190.00	2,929.68	260.32
Federal insurance contributions act	273.39	239.77	33.62
Indiana unemployment compensation and excise tax -----	64.01	431.92	( 367.91)
Fifty-year club-----	422.55	245.04	177.51
Women's Auxiliary to I.S.M.A. -----	-----	298.77	( 298.77)
General practitioner award -----	1,218.00	476.04	741.96
Anti-National Health Insurance Committee -----	5,985.53	6,186.10	( 200.57)
Interim session ---	297.00	-----	297.00
Total disbursements—Exhibit A -----	178,193.24	113,731.34	64,461.90

**CASH BALANCE AT**

**END OF YEAR** \$ 20,602.36 \$ 69,449.55 \$(48,847.19)

**Exhibit D****INDIANA STATE MEDICAL ASSOCIATION****Statement of Cash Receipts and Disbursements,**

**Year Ended December 31, 1953**

**THE JOURNAL OF THE INDIANA STATE  
MEDICAL ASSOCIATION**

**BALANCE, JANUARY 1, 1953** --- \$ 4,960.47

**RECEIPTS:**

Subscriptions—members—	
Exhibit C -----	\$11,199.00
Subscriptions—non-members ---	372.00
Advertising -----	29,087.73
Collections on accounts receivable	303.10
Single copy sales -----	167.25
Electrotypes -----	9.50
Sale of civil defense reprints ----	.70
Total receipts—Exhibit A-----	41,139.28
	46,099.75

**DISBURSEMENTS:**

Salaries -----	8,877.50
Printing -----	29,531.61
Office postage -----	231.14
Journal postage -----	599.96
Electrotypes -----	1,209.06
Press clippings -----	152.70

Office supplies -----	270.46
Rent -----	480.00
Electricity -----	51.58
Telephone and telegraph -----	233.89
Federal insurance contributions--	125.89
Indiana employment compensation and excise -----	31.19
Art work -----	95.60
Miscellaneous -----	447.21

**Total disbursements—**

Exhibit A ----- 42,337.79

**BALANCE, DECEMBER 31, 1953—Exhibit B** \$3,761.96

**Exhibit E****INDIANA STATE MEDICAL ASSOCIATION****Statement of Cash Receipts and Disbursements,**

**Year Ended December 31, 1953**

**MEDICAL DEFENSE FUND**

**BALANCE, JANUARY 1, 1953** ---- \$4,318.35

**RECEIPTS:**

Transfer of applicable portion of dues from the general fund—	
Exhibit C -----	\$ 4,387.50
Interest income -----	492.60

Total receipts—Exhibit A ---- 4,880.10

9,198.45

**DISBURSEMENTS:**

Malpractice fees -----	747.57
Attorney fees -----	2,190.00

Total disbursements—Exhibit A 2,937.57

**BALANCE, DECEMBER 31, 1953—Exhibit B** \$6,260.88

**CHAIRMAN OF THE COUNCIL**

The past year has been a very busy one for the Council of the Indiana State Medical Association, and in this brief report no more can be done than hit the high spots in reporting some of the things brought before that body and the action taken on them.

In general, every encouragement possible has been given by the Council to such Association projects as the Medical Education Foundation Fund, the Preceptorship Plan, Physician Placement Program, and Medical Forums.

The Preceptorship Plan was approved both by the Council of the Medical Association and the Council of the Indiana University School of Medicine, and it is now in operation.

The idea of Medical Forums was approved, and successful forums have been held in several localities in the state, Evansville taking the lead in this.

State liaison committees with labor and with the State Department of Public Welfare were authorized or approved by the Council, also a standing committee on Medical Court Testimony was estab-

lished, with one member named from each Council District.

Better cooperation with the Woman's Auxiliary to the Indiana State Medical Association has been attempted with the result that the aims and aid of the Auxiliary have been directed to more advantage, particularly along the lines of nurse recruitment, the Medical Education Foundation, and wider distribution of the magazine, "Today's Health".

After a survey was held, it was deemed unnecessary to hold compulsory pre-council meetings of the officers of the component county societies, as these meetings were not being well attended. Also, the interim meeting of the House of Delegates was held to be an unnecessary expense for the amount of good which came out of it. The Council recommended that these two changes be made, which was done by the House of Delegates.

The Council also recommended lowering the annual dues by \$5.00, which recommendation was followed by the House of Delegates after a stormy debate.

New suggestions for Indiana licensing regulations were made by the Council (Cf. p. 1303, Dec. 1953 Journal), also suggestions on the turbulent question of Hospital accreditation were made, most of which were adopted with modification by the House of Delegates (pp. 1318-1319, Dec. 1953 Journal).

Rules for selection of the Physician of the Year were clarified, broadening the basis for selection to include any member of the Association judged by the House of Delegates "to have given the most outstanding and unselfish devotion to the high precepts of his profession", and a plaque was devised as an annual award.

Kenneth W. Bush of Indianapolis was selected as field representative for northern Indiana, beginning his work October 1, 1953. He and Robert Amick, field representative for southern Indiana, have been active in carrying the work of the Association to the county medical society meetings. Recently, their work has been broadened and enhanced by taking pictures at these local meetings, which have added much interest when published in THE JOURNAL.

Robert Hollowell, prominent Indianapolis attorney, was added to the legal staff of the Indiana State Medical Association, beginning his work October 1, 1953. He has had extensive experience in codifying the state health laws, writing the legal phase of hospital regulations and in teaching at the Indiana University School of Medicine about regulations concerning communicable diseases and public health laws.

The January meeting of the Council was a long, exhausting one including as it did among other things—an audited financial report, a membership report by districts and counties, an item by item discussion of the budget for 1954, and discussion of legislative and organization matters.

Dr. Porteus suggested a plan for the staggering of membership on state committees, which will be presented to the House of Delegates in the form of an amendment to the By-Laws.

The Board of Appeals on Patient-Physician Relations requested the additional appointment of a psychiatrist to their number, which request was granted.

A paid advertising campaign was discussed, and the sum of \$25,000.00 was set aside for this purpose, the same to go to the Committee on Public Relations.

The Council gave authority for the formation of an inter-professional council among the allied ophthalmologic professions.

It was brought to the attention of the Council that the course in Medical Economics formerly taught by Dr. Cy Clark had been discontinued, and a request was made to have it reinstated in the curriculum, which request is being honored.

The Porteus Unity Plan, which was presented for the purpose of extending the annual meeting by one day, on which the various ancillary medical groups would be invited to come in and hold their meetings, was brought before the Council and is now in the hands of a committee, of which Dr. Kenneth Olson is chairman. This proposal is expected to come before the House of Delegates at Indianapolis in October.

ELTON R. CLARKE, M.D.  
*Chairman of Council.*

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## Reports From District Councilors

### FIRST COUNCILOR DISTRICT

The affairs of the First District seem to be in good condition. We have several counties with small membership whose formal meetings are limited, but from an educational standpoint the large county society meetings are open and attended by a comparatively good representation from outside society members. There has been in the past year some talk of consolidation of different counties but to date nothing has been accomplished in this regard.

The district association will meet in Tell City on the third Thursday in September, 1955, at which time a tentative plan is to have state officers meet with us and detail whatever plans and information they may care to impart to us.

MINOR MILLER, M.D., *Councilor*.

### SECOND COUNCILOR DISTRICT

As the final year of my term as Councilor is about to end, I can reflect with pleasure upon the many acquaintances I have made during that period of service, confreres who I might not otherwise have had the opportunity of meeting and dis-

cussing matters of importance from professional and legislative fields. It has been a most worthwhile and instructive experience that I shall be happy to pass along to my yet unknown successor.

I regret the conflicting dates of three national conventions during the past year which prevented my attendance at the last three Council meetings—however, Dr. Sam Rotman represented the district as alternate.

Most of the legislative program of the 83rd Congress confirms the validity of my objections to the elevation of the Federal Security Agency to cabinet status. One has but to recount the numerous instances of administration pressure applied to our representatives through that new Department of Health, Education and Welfare. Such executive pressure brought about the passage of increased social security coverage for most professions, except the doctors. The only reason they were not included this year was because of the grass-roots expressions sent to Washington after doctors were alerted by their state and county organizations. This was an outstanding example of what public opinion can do to stop bureaucratic designs. It should have been done many more times during the past two years. A less widespread alert did prevent the passage of the Health Reinsurance Bill which would have set up another federal corporation to force private insurance companies to take on actuarially unsound risks which

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could only be paid for by additional taxation. Despite the exclusion of doctors from the compulsion of the extended Social Security Act, that new law embodies the opening wedge of socialized medicine in Section 106. By virtue of that section, the Secretary of Health, Education and Welfare is empowered to hire physicians to examine OASI recipients for certification of total disability. Every attempt will be made to expand that wedge into full-fledged socialized medicine, unless demands are made immediately to our legislators for its repeal. No physician who appreciates the dangerous nuances of socialistic planning can ever with honor and integrity agree to sell his services to and for such a scheme. By now, it should be common knowledge that organized medicine was hoodwinked into endorsing the addition of a Department of Health, Education and Welfare for the President's cabinet. The promised consultations on medical matters have not been forthcoming, and the "half loaf" of bread has turned out to be but crumbs. Organized medicine and individual physicians must learn not to compromise on basic principles.

In contrast to this less desirous background there is a shining example of worthy achievement in the A.M.A. stand on non-service-connected disabilities of veterans. Here is at least one instance where individuals fighting for the preservation of the American way of life have adhered to the essential principles that have withstood the test of time over a century. For this honorable stand, the people of this nation will eventually pay tribute to those who held steadfast on the only solid foundation we have to guide us—the morals taught throughout history.

May the integrity of purpose as exemplified in our position denying special class privilege to all veterans, extend to all the problems facing the Indiana State Medical Association and the AMA, for the purpose of restoring faith in righteous tenets that have been all but sacrificed for the atheistic theories of Karl Marx and his too numerous disciples.

A. G. BLAZEY, M.D., *Councilor.*

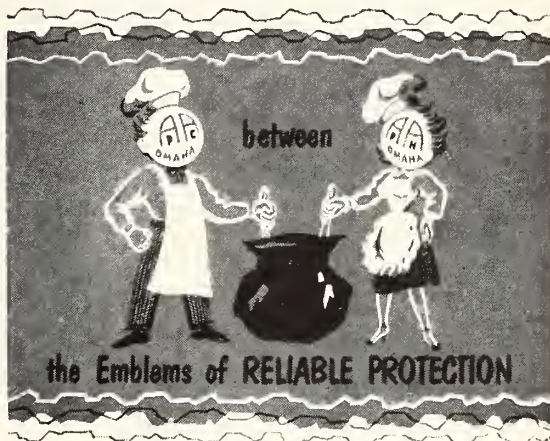
### THIRD COUNCILOR DISTRICT

The Third Medical District Society held its annual meeting at the Dubois Country Club at Jasper, Indiana on May 26 with an attendance of approximately 65 doctors and their wives representing the 11 counties of the district.

An outstanding scientific program was presented and included a paper on the "Artificial Kidney Operation" given by Dr. George Lukemeyer, Indiana University Medical Center. Dr. Patrick Corcoran of Evansville discussed the use of drugs in modern medicine, and Ed Klingler of The Evansville Press, spoke at the dinner meeting on "Politics and You."

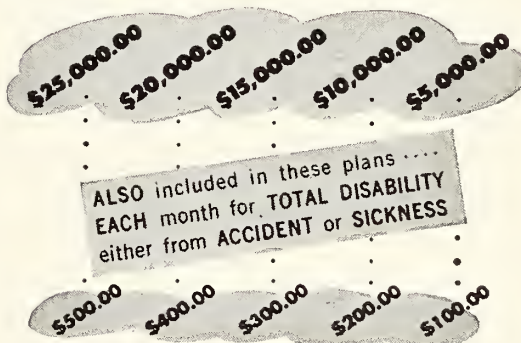
The Third District was fortunate in having in attendance the president, Dr. Wm. Harry Howard

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of Hammond, who spoke on the Association activities and also the presence of the executive secretary and the field secretary for the district.

At the business session Dr. John M. Paris of New Albany, was elected district president and will select his own officers for the coming year. The 1955 meeting will be held in New Albany.

WM. H. GARNER, M.D., *Councilor*

#### FOURTH COUNCILOR DISTRICT

The Fourth Medical District held its annual meeting at the Seymour Country Club, May 5, 1954 and celebrated its Fiftieth Anniversary. The Jackson County Medical Society and its Auxiliary served as hosts. A golf tournament was held during the morning for the doctors and their wives. A tour of the Central Pharmacal Company, and bridge and Canasta entertained those who did not care to play golf.

At noon a very fine luncheon was served and enjoyed by about 200 members and guests. The State Association was represented by Dr. Walter Portteus, president-elect, Mr. James Waggener, executive secretary, and Mr. Robert Amick, field secretary. These gentlemen spoke briefly at the luncheon. The State Auxiliary was represented by Mrs. Frank Gastineau, national AMEF chairman, Mrs. Roy V. Myers, secretary, and Mrs. F. G. Mountain, vice-president.

Following the luncheon a scientific meeting was held. Dr. G. H. Kamman of Seymour gave a paper, "Fifty Years of Medicine in the Fourth District". He recounted many of the early meetings, and interesting incidents that had happened in the district during its 50 years.

Dr. Rudy F. Vogt, Assistant Professor of Obstetrics and Gynecology of the University of Louisville, gave a paper, "Treatment of Common Complications of Pregnancy". This was a very practical paper which was well received and thoroughly discussed by the membership. Dr. Vogt very obligingly answered the many questions of the members.

Dr. Frank B. Ramsey, Assistant Professor of Surgery at Indiana University School of Medicine, presented a paper, "What Should a Patient With Cancer Be Told?" This paper aroused much interest among the members, and should prove helpful to them in their dealings with their cancer patients. This paper, too, was thoroughly discussed, and Dr. Ramsey also answered many questions for the members.

At the close of the scientific session the following new officers were elected for the coming year: President—Dr. Wm. C. McConnell of Sunman; Vice-President—J. C. Elliott, Guilford; Secretary-Treasurer—Dr. S. George Row of Osgood. The next meeting will be held Wednesday, May 4, 1955, at Batesville.

The Medical affairs of the Fourth District are in good order at this time.

J. E. DUBBING, M.D., *Councilor*.

#### FIFTH COUNCILOR DISTRICT

The meeting of the Fifth District Medical Society was held at the Country Club of Terre Haute on May 19, 1954.

An interesting scientific session was held with Dr. S. R. Combs presiding. Dr. John V. Thompson spoke on "Thoracic Surgery". Dr. Emmett B. Lamb discussed "Treatment of Varicose Veins". Dr. L. H. Kornafel spoke on "Thyroid Disease".

At the business meeting, the following officers were elected for 1954: Dr. Paul Casebeer, Clinton, President; Dr. O. L. Wood, Brazil, Secretary-Treasurer; Dr. Earle V. Wiseman, Greencastle, Alternate Councilor; and Dr. M. C. Topping, Terre Haute, Councilor.

The meeting in 1955 will be held in Parke-Vermillion Counties on Wednesday, May 18 unless this date presents conflict with other district meetings.

At the banquet, officers of the State Medical Association were introduced and Dr. Howard spoke briefly upon the progress and problems of the Association. Entertainment followed the banquet. The principal speaker was Dr. W. P. Allyn of the faculty of Indiana State College, his subject was "Snakes".

M. C. TOPPING, M.D., *Councilor*.

#### SIXTH COUNCILOR DISTRICT

The Sixth District has to report a normal year of harmony, progress in scientific attainment and unity in political matters concerning the profession.

Each component society has met regularly with excellent attendance and good programs. Throughout the district, the various societies have emphasized the social side, feeling that increased social relations result in better acquaintance, better interest and that the public profits by friendly interchange of opinions among the doctors.

Hospital accommodations are ample, full laboratory and anesthesia services are available in each county.

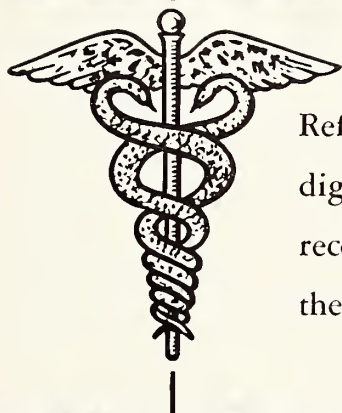
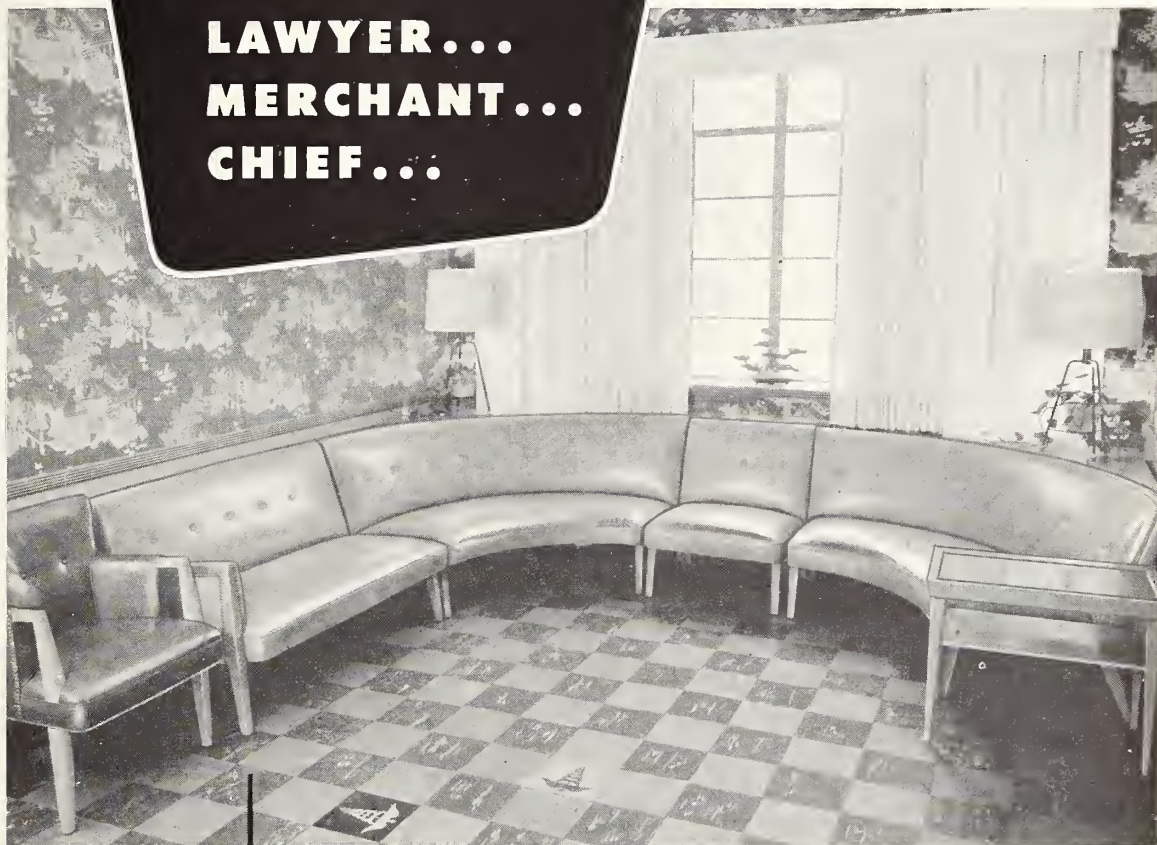
There has been a considerable participation in civic affairs, such as the Red Cross, Cancer, TB and Heart campaigns, all of which have, in general, been under medical supervision.

Politically, the doctors responded well to the request of the AMA to send telegrams to Congress concerning the Social Security law.

Candidates of the heavily predominant political party, who are reasonably certain of election, have been contacted and without exception may be



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depended upon to uphold medical viewpoint in the Legislature and Congress.

The District meeting at Shelbyville was the usual and expected success. The secretary, Dr. Tindall, arranged an excellent program and a good dinner. He also arranged meeting with the Women's Auxiliary and joining in the dinner. The president, Dr. Kuhn, closed many years of faithful service and was succeeded in office by Dr. John E. Fisher, in our usual promotion procedure, Dr. Tindall moving to vice-president and Dr. C. E. Sheets of Manila becoming secretary.

The District has found sequential promotion for its officers very satisfactory.

The meeting was honored by the attendance of Dr. Walter Portteus, who spoke in his usual felicitous manner.

The Councilor, Dr. Kennedy, reviewed the year's work with emphasis on continuing political activity and unity, and expressed his appreciation of the loyal and generous support of the District members. The next meeting will be April 22, 1955 at Brookville.

W. U. KENNEDY, M.D., *Councilor.*

#### SEVENTH COUNCILOR DISTRICT

The Seventh District Medical Society met May 11, 1954, in the auditorium of the Student Union Building of Indiana University Medical Center, Indianapolis. Doctor Emile Hohman, of Stanford University School of Medicine, was the guest

speaker. The title of his paper was, "The Surgical Treatment of Constrictive Pericarditis with Clinical and Experimental Observations." Dr. Elmer Koch of Danville presided.

Excellent cooperation by all counties was evident from telegrams to Congressman Reed to exclude physicians from Social Security Bill. Morgan County sent 16 telegrams, Johnson County, 19 telegrams, and an undetermined number were sent from Hendricks and Marion Counties.

The fall meeting was held in Indianapolis, September 25, 1954, at the Indianapolis Athletic Club. This was a dinner-dance sponsored by J. B. Roerig Company of Chicago. The business meeting was held at 5:30 p.m. for election of officers; refreshments at 6:30 p.m. C. Walter ("Micky") McCarty was the toastmaster.

I have visited the Hendricks and Indianapolis Medical Societies and Morgan and Johnson County Societies have been contacted several times by phone.

The Indianapolis Medical Society sponsored a three day Marion County Health Fair at the State Fair Grounds in April 1954; 15,000 attended.

The general condition of the medical profession in this district is good.

LESTER D. BIBLER, M.D., *Councilor.*

#### EIGHTH COUNCILOR DISTRICT

The Eighth Councilor District annual medical meeting was held at the Delaware Country Club

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on May 19, 1954 with Randolph County Medical Society as the host.

An afternoon of golf by some and good fellowship by others initiated the meeting.

At a short business meeting in the evening Dr. Guy Owsley was elected as Councilor for this district. Dr. J. S. Fitzpatrick was elected to the office of president and Dr. S. M. Hammond to secretary-treasurer.

We sincerely appreciate the presence of and the effort expended by our president-elect, Dr. Walter Portteus, and our executive secretary, Mr. James

Waggener, in attending the evening portion of the meeting.

The scientific portion of the program was given by Dr. H. B. Shumacker, Jr., a very interesting and informative talk on the history of and present status of blood vessel surgery.

T. R. HAYES, M.D., *Councilor*.

#### NINTH COUNCILOR DISTRICT

The annual Ninth Councilor District Medical Society meeting took place at the Ulen Country Club in Lebanon, on May 12, 1954. All counties except White County were represented by delegates. Dr. Walter L. Portteus, president-elect, and Mr. James A. Waggener, Executive Secretary of the Indiana State Medical Association, attended the meeting. Mr. L. E. Converse of Blue Shield also attended the meeting.

Mr. Converse, in accordance with the 1953 annual meeting asked that a Medical Advisory Council be set up. Following discussion Dr. James W. Crain moved that the delegates to the district meeting be members of the Medical Advisory Council unless the respective component societies wished to appoint a member other than the regular delegate. The motion was seconded by Dr. Gordon Thomas, and passed.

Dr. Lee J. Maris moved and Dr. Crain seconded that the Fountain-Warren Society be host for the 1955 meeting.

A very fine scientific program was held in the clubhouse during the afternoon. Speakers were Drs. Frank Teague, C. A. Stayton, Jr., and J. C. Katterjohn, Jr., all of Indianapolis, and Dr. James M. McFadden, Lafayette.

The Wabash College Glee Club provided the entertainment following the banquet in the evening. Attendance at the meeting was good despite the meeting of the Alumni Association of Indiana University School of Medicine.

WEMPLE DODDS, M.D., *Councilor*.

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## TENTH COUNCILOR DISTRICT

The past 12 months period under the presidency of Dr. Ralph Eades of Valpariso has been one of the Tenth District's finest. Attendance at our meetings, especially from the counties other than Lake, which lie at some distance from the meeting sites, improved considerably.

At an afternoon-evening meeting October 7, 1953 at Phil Smidt's the Indiana Academy of General Practice presented its annual "Road Show" to about 125 physicians whose wives were holding a separate but simultaneous meeting of the Tenth District Auxiliary. This meeting was presided over by Dr. Lee Hickman of Hammond, president, who conducted an election resulting in Dr. Eades' selection as president and Dr. Herbert Ashmore, Hebron, as secretary. At this time, also, Dr. J. Robt. Doty of Gary was chosen Tenth District Councilor, and Dr. J. P. Vye of Gary, alternate.

Dr. Lester Bibler, representing the IAGP, presented the "Road Show" program. First speaker was Dr. E. Gray Dimond, Chairman of the Department of Medicine, University of Kansas, who spoke on "Cardiac Surgery". In the evening program, Dr. Dimond discussed the relationship between medical schools and private practitioners. Both talks provoked considerable discussion and applause. The second speaker was Dr. R. J. Pieri, Professor of Obstetrics and Gynecology, New York University and Vice President of the International College of Surgeons, whose film and talk on "The Use of Obstetrical Forceps" was excellent.

Guests of honor at the meeting were Dr. Harry Howard, President-elect of the Indiana State Medical Association, and Mrs. Sue Matthews, President of the ISMA Woman's Auxiliary. The Spring meeting, May 12, was unusual in that it was held for the first time, outside the geographic limits of the district, at Norman Beatty Hospital in Westville. The program was an all day series of talks and hospital tours. Of unusual interest were tours of maximum security wards, and demonstrations of electric and insulin shock therapy on the hospital's patients.

In addition to talks by Dr. W. R. VanDenBosch, hospital superintendent, and members of his staff, Dr. Francis J. Girty of Northwestern University spoke on "The Use and Misuse of Psychiatry in General Practice", Dr. Virginia Apgar of New York University spoke on "Infant Resuscitation and Mental Effects", and in the evening an unidentified Chicago member of Alcoholics Anonymous described the work of the A. A.

The next meeting of the Tenth District Society will be another IAGP "Road Show", held at Vogel's Restaurant in Whiting on October 14, beginning at 4:00 P.M. at which Dr. Don Bowers of Indianapolis will speak on cancer, and Dr. George J. Thomas of Pittsburgh University will present his popular talk-demonstration on operating room hazards.

J. ROBT. DOTY, M.D., *Councilor*



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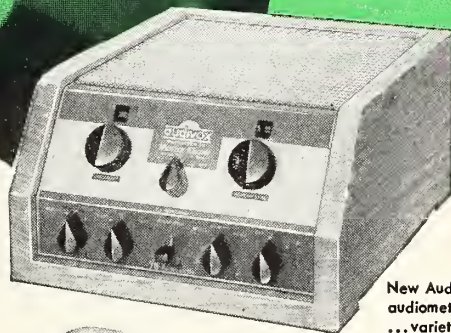
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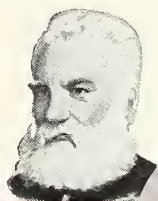
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**ELEVENTH COUNCILOR DISTRICT**

The fall meeting of the Eleventh District Medical Society was held at the Moose Home in Huntington, September 16, 1953. Dr. Cecil G. McEachern of Fort Wayne spoke on "Differential Diagnosis of Abdominal Pain", and Dr. Leonard Condon of Chicago on "Medical Emergencies".

In the business meeting, Dr. Max R. Adams of Flora was named Alternate Councilor.

At the evening meeting, Mr. J. C. Brenn of the Huntington Laboratories gave an interesting talk on "Socialism and Communism in Europe", based upon a recent visit to that continent.

The spring meeting was held at Marion, May 19, 1954; the afternoon session at the Veterans' Hospital. A group of four doctors from Ford Hospital, Detroit, presented a panel discussion of "Medical and Surgical Aspects of Gastroenterology". Those participating were Drs. James Baltz, Conrad R. Lam, Robert J. Priest and Brock E. Brush.

At the dinner meeting held at the Izaak Walton League camp, near Marion, music was furnished by the Marion Male Chorus, and the principal speaker was Tom Hendricks from A.M.A. headquarters, discussing current A.M.A. policy.

The Eleventh District is proud of having been selected as the pioneer district in the formation of Blue Shield Advisory Committees. An active panel has been selected with a representative from each of the seven counties comprising the district, and with as much spread as possible among the types of practice. It is hoped with the formation of these district groups to take off some of the load from the State Blue Shield Board of Directors.

The following members or former members died during the past year: Dr. N. Howard Thompson, 81, formerly of Wabash, June 29, 1953. Dr. Frederick S. Cuthbert, 77, Kokomo, November 20, 1953; Dr. James Roger Ward, 41, Huntington, April 1, 1954; Dr. Lucian W. Smith, Warren, April 4, 1954; Dr. Walter McBeth, 78, Royal Center, June 25, 1954.

Reports from the individual counties follow:

**Carroll County**—No report received.

**Cass County**—Activities recently consisted in operation of an emergency call list and cooperation with the Indiana Heart Foundation on its weight control program.

Drs. Earl Bailey, Donald K. Winters and Brice E. Fitzgerald have been appointed medical examiners to the Cass County Selective Service board.

Dr. Charles A. Ballard, Logansport, was appointed Cass County health officer for a four year term.

Recent additions to the staff of the Logansport State Hospital are: Drs. Robert Maschmeyer, E. B. Phipps and John H. Grant.

**Grant County**—Dr. George R. Daniels of Marion

recently resigned as Grant County coroner and was appointed Grant County health officer.

Dr. Henry Alderfer of Marion was appointed county coroner to complete Dr. Daniels' term.

Dr. P. L. Sthair of Marion was appointed County Home physician for one year.

Dr. Stewart T. Ginsberg, who has been chief of professional services at Marion VA Hospital, has been made manager of a new neuropsychiatric hospital near Pittsburgh, Pa.

**Howard County**—New members of the society are: Dr. George A. Kremers, urology, Dr. Warren McClure, general practice, and Tom W. Wachob, Jr., gynecology and obstetrics, all in Kokomo.

The following physicians recently passed specialty boards: Dr. John H. Alward, Diplomate in Surgery, Dr. Reuben Craig, Diplomate in Pediatrics, and Dr. Max M. Earl, Diplomate in Internal Medicine.

Dr. Richard P. Good has been appointed Chairman of the Visiting Committee, State Hospital Board.

Howard County physicians participated in a Health Workshop under the direction of the Woman's Auxiliary at Russiaville, September 30, 1953.

A group of Howard County physicians met in November to form a Medical Study Group, which meets once a month on the fourth Tuesday to discuss current medical topics. The members take turns in leading the discussion in a subject of their choice. Attendance and interest in these monthly meetings have been very good.

Dr. R. P. Good was on the program of the Indiana Chapter of the American College of Surgeons at its meeting in Indianapolis in June.

Dr. Copeland Bowers was named one of the District Governors of Lions International this year.

Dr. Garvey Bowers was elected President of the Kokomo Kiwanis Club.

**Huntington County**—Dr. Richard W. Wagner has entered general practice in Huntington. He has been named county physician for 1954 and also elected secretary of the Huntington County Medical Society.

Dr. Thomas James, Jr. has been appointed Huntington County health officer.

**Miami County**—New members: Dr. G. P. Diamiani, Peru, and Dr. Lloyd Hill, Denver.

Dr. L. D. Lewis was appointed resident physician at Wabash Valley Employees' Hospital at Peru, replacing Dr. Robert Hayes, who has joined the U. S. Air Force.

**Wabash County**—Dr. J. T. Steffen was elected President of the Chamber of Commerce of Wabash.

Dr. William Dannacher of Wabash designed the "Irri-Mat", a self-irrigating suction apparatus.

ELTON R. CLARKE, M.D., *Councilor*.



## TWELFTH COUNCILOR DISTRICT

The Twelfth District Medical Society held its annual meeting at Columbia City May 19, for which the Whitley County Medical Society acted as host. Due to rather poor attendance in recent years it had been decided that the greatest value in the district meetings was in promoting the acquaintanceship of the physicians in the district and mutual friendship and understanding and with this idea no scientific program was held. The host society provided an afternoon of relaxation on a nearby golf course and a picnic at a nearby lake and a dinner meeting at the local American Legion Home which was very well attended, followed by an evening of entertainment.

A business meeting was held at 6:00 p.m. and the following officers were elected:

President . . . . . Robert W. Wilkins, Fort Wayne  
 Vice-president . . . . . Jack L. Eisaman, Bluffton  
 Secretary-treasurer . . . . . Jules K. Heritier,

Columbia City

A motion was passed at this meeting that dues of one dollar per year be charged to each member of the district society and that these dues be collected by the treasurer of the component societies and transmitted to the treasurer of the dis-

trict society. At the invitation of the Noble County Medical Society the next meeting of the district society was voted to be held at Kendallville the third Wednesday in May, 1955 with the Noble County Medical Society as host and in charge of the program.

A Blue Shield Advisory Committee was formed composed of members of the component societies during the past year and has had a total of three meetings. Dr. Frank Thompson has been elected chairman of this group. The last meeting was held on May 19 in conjunction with the District Meeting and was attended by Dr. Walter Portteus, president-elect, James A. Waggener, executive secretary, Kenneth Bush, field representative, and L. H. Converse of Blue Shield. This committee promises to be an important activity for the district society.

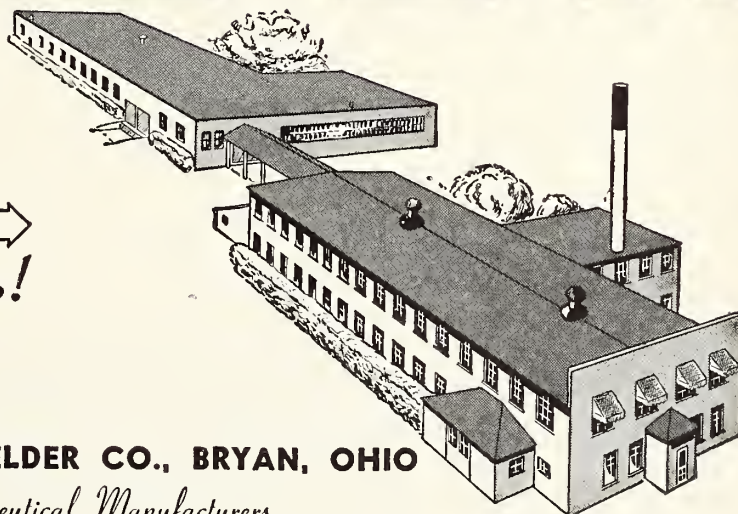
MAURICE E. GLOCK, M.D., *Councilor.*

## THIRTEENTH COUNCILOR DISTRICT

The Medical Societies comprising the Thirteenth Medical District have been holding regular business and professional meetings during the year. The increase in required attendance at various hospital meetings to continue as a member of the staff has produced some suggestions that the County Medical

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Society not have as many meetings. It is possible that the required attendance at hospital meetings may produce a lessened interest in the county society meetings. So far we have maintained our county society meetings as in the past. Generally the county societies have been functioning well and there has been no unusual incident in the District during the year.

The annual meeting of the Thirteenth District Medical Society was held in South Bend on Wednesday, November 18, 1953. The meeting was an all day affair as has been the custom in the past several years.

The morning program was held at the South Bend Medical Foundation and the first paper presented was "Cat Scratch Disease and Oculo-glandular Conjunctivitis" by J. V. Cassady, M.D. and Carl S. Culbertson, M.D. The second paper was entitled "Experiences with Cultures of Surgical Tissues" by Thomas P. Potter, M.D.

Following the morning session a luncheon was held at the LaSalle Hotel in South Bend and following the luncheon a business meeting was held at which time the officers for the year 1954 were elected.

The list of elected officers is as follows:

Otis R. Bowen, M.D., President  
 Hugh Miller, M.D., Vice-President  
 O. E. Wilson, M.D., Secretary-Treasurer  
 K. L. Olson, M.D., Councilor  
 G. O. Larson, M.D., Alternate Councilor

The latter two were elected for a three year term.

Following this W. H. Howard, M.D., President of the Indiana State Medical Association, gave a talk in regard to the activities of the Indiana State Medical Association. The talk was interesting and the society was honored by having the President of the State Medical Association at its meeting.

A scientific program in the afternoon consisted of a talk entitled "Hematuria" by William J. Baker, M.D., Professor of Urology, Cook County Hospital, Chicago. The second paper was entitled "Diabetes in General Practice" by Harry T. Rocketts, M.D., Professor of Medicine, University of Chicago, Chicago.

The third paper was entitled "The Possibilities of Plastic Surgery" by Claire L. Straith, M.D., Straith Clinic, Detroit.

Following this the doctors and their wives met for cocktails and a social hour before the dinner which was held at 7:00 p.m. at the Indiana Club.

The speaker for the evening was Edward J. McCormick, M.D., President of the American Medical Association. We were, indeed, fortunate in being able to have Dr. McCormick as our speaker. He gave a most interesting talk on the activities of the American Medical Association and the doctors and their wives were very much impressed.

On the same day the Woman's Auxiliary of the Thirteenth District had a meeting and joined the doctors for cocktails and dinner. We had an excellent attendance.

The next annual meeting of the Society will be held in November, 1954.

KENNETH L. OLSON, M.D., *Councilor*.

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FRANK B. NORBURY, M.D., Associate Physician

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# Reports of Committees

## EXECUTIVE COMMITTEE

Since the last meeting of this House, the Executive Committee has been occupied with handling the many responsibilities assigned it. Meeting regularly, the committee has endeavored to handle the many affairs for the association which could not be deferred until the meeting of the Council. Even so, major policy decisions have been referred to the Council for final determination.

It is apparent to your Executive Committee, from the volume of matters which come before it, that the activities and interests of the Association have expanded during the past few years.

### Field Service

It is the opinion of your committee that the activities of the two field secretaries have proven of great benefit to the Association. This service has been responsible for keeping the membership fully informed on matters of importance, and has served to establish a better liaison between the Association and the members. Help of the field service has assisted in reactivating some of our smaller societies and today is serving the component societies in arranging programs, etc.

### Legislation

The past year has been an active one from a legislative standpoint. The American Medical Association has at various times requested cooperation on matters of national legislation.

### Annual Convention

The committee is happy to report the receipt of many letters of praise from exhibitors for the excellent quality of the 1953 annual convention at French Lick. Exhibitors were high in their praise for the courtesy and attention given them by the membership and many have already requested space for the 1955 meeting. The increased promotion of the part the exhibitors play in our meetings, and the splendid cooperation of the membership has gained for Indiana the reputation of having one of the finest meetings in the nation. We are sure as you visit the exhibit halls this year, you will agree, the interest of exhibitors has increased tremendously. Income from the sale of exhibit space for the 1954 meeting exceeds \$20,000.

Through cooperation of the Studebaker Corporation, the committee approved the awarding of a new Studebaker to some Indiana physician during the 1954 meeting. The money which was to be taken from the exhibit income for this purpose will now be used to award additional gifts and to award a major gift to some exhibitor. Since the exhibitors do play such an important part in

making our convention a financial success as well as an educational success, your committee felt it only proper that the Association should, as an organization, reward them for their efforts in making the Indiana convention the outstanding meeting it is now recognized as being.

### Reports Printed

The committee does not propose in this report to go into minute detail regarding all the matters which have come before it as these have been published regularly in the minutes of the committee in *THE JOURNAL* and members of the reference committee will be supplied with copies for their review. However, we do desire to call your attention to a few of the matters.

In accordance with the action of the 1953 House of Delegates, the committee did prepare for introduction before the AMA House of Delegates a resolution on Accreditation of Hospitals, which was adopted by the AMA.

### Doctors' Office Assistants

One of the forward steps taken public relations-wise has been the assignment of the field staff to cooperate with the Blue Shield Plan in holding meetings for employees of physicians. At these meetings, the staff occupies a part of the program for the purpose of discussing medical public relations from a doctor's office assistant standpoint, encouraging her to take more care in her public relations responsibilities, and passing out a booklet on this subject, prepared especially for office assistants by the American Medical Association.

Another project which we feel was a forward step in our public relations effort was the cooperation with the State Sunshine Society in furnishing a medical speaker for their annual state meeting. This is an organization of senior high school girls, and the attendance for the program approximated 2,500.

### Inter-State Cooperation

The executive committee would like to report that during the year, a meeting was held in Indianapolis at which time the Presidents, Executive Secretaries and in some cases, other officers of the State Medical Association of Illinois, Wisconsin, Ohio, Michigan and Kentucky met for the purpose of discussing matters of mutual interest to physicians of these states. The meeting was heralded as a great success, and the group was of the opinion these meetings should be continued. A permanent organization was established and the second annual meeting of this group will be held in Lansing, Michigan during the middle of November. We feel these get-togethers should be



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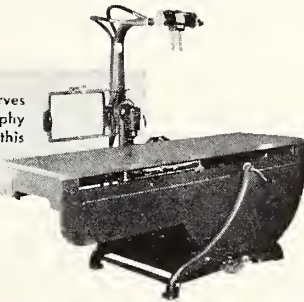
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continued through participation of our Association as the importance of these states from an economic and medical point of view cannot be underestimated. Through this organization we have an opportunity to sit together and discuss frankly and openly every subject which has an important bearing upon the practicing physicians of our states.

#### Cameras for Field Staff

Also in accordance with instructions of the Council the committee purchased camera equipment for use of the field staff, and we are sure many of you have seen the results of this equipment in issues of *THE JOURNAL*, where each month photographs appear taken during the many meetings held in our state.

#### Conference on Patient Care

Through action of your committee the Association participated in a conference on patient care. This was a meeting of physicians, hospital administrators and nursing personnel, to discuss methods of improving the quality of patient care. This meeting was the outgrowth of recent action of the American Medical Association, encouraging such conferences on the state level.

#### Malpractice Insurance

One of the most important matters handled by your committee has been the matter of malpractice insurance. The committee has made a thorough study of this matter, and decided to survey the membership as to their wishes on this matter. The result has been discouraging from the standpoint there seems to be little interest in the Association taking any steps as such which might lead to a more favorable rate structure for our members.

To review this matter, several years ago the Association entered into an agreement with St. Paul Mercury Indemnity Company to write malpractice insurance for the members. At the time, a special committee of the Association had worked to prepare a set of standards for the protection of the membership. St. Paul was willing to write such a policy, but the Association has never actively promoted the program. As a result, the plan has a very small number of physicians taking advantage of the plan in proportion to the total eligible membership, and physicians generally have purchased their insurance from whatever source they chose. It was the belief of the committee that if the enrollment could be increased whereby a more satisfactory spread of the risk would be possible for one company the rates should be reduced.

We requested the field representatives to discuss this with their societies and found that opinion was that the Association should not actively promote this company, and that physicians should continue to purchase their insurance from

whatever source they desired. As a further result of this, it appears that malpractice rates show little chance of being reduced under this plan. It is not the intent of the committee to belabor this matter, nor to make any recommendations, but in view of the number of inquiries made, we desire to inform the House of our activities in this matter, and the result of our survey. In not pursuing this matter further, we assume we are abiding by the wishes of the membership.

#### Membership Report

Listed here is a detailed membership report. You will note the first column of figures indicates the total membership of each county society as of December 31, 1953. The second column gives the membership as of September 1, 1954. The fourth column indicates the number of physicians in each county who are delinquent with their 1954 dues. It should be understood this latter figure not only includes those who have not paid their dues, but also those physicians who are members of the respective societies and who are eligible for Senior membership, those excused from paying dues because of being in military service and for whom the state office has not received a receipt from the county society so stating.

#### MEMBERSHIP REPORT Indiana State Medical Association

County Society	Members 12-31-53	Members 9-1-54	Members 9-1-54	Number Delinquent	A.M.A. Non-members
Adams	14	13	13		
Allen	214	212	218		
Bartholomew-Brown	36	35	33		
Benton	10	10	11		1
Boone	19	19	20		
Carroll	9	9	9		
Cass	38	38	36	1	2
Clark	30	30	32	1	2
Clay	11	11	13		
Clinton	22	22	22		1
Daviess-Martin	25	25	27		1
Dearborn-Ohio	15	15	15		
Decatur	11	11	13		
DeKalb	21	21	20		
Delaware-Blackford	96	95	96	8	8
Dubois	18	18	20		4
Elkhart	88	88	94		3
Fayette-Franklin	17	17	21		1
Floyd	35	32	33	1	1
Fountain-Warren	16	16	16		
Fulton	12	12	12		
Gibson	24	24	22		
Grant	50	49	51	1	
Greene	20	20	21		11
Hamilton	21	21	20		10
Hancock	15	14	18	1	3
Harrison-Crawford	11	11	12		1
Hendricks	16	14	16		
Henry	41	41	37		2
Howard	42	42	42		
Huntington	22	22	21		1

County Society	Members 12-31-53	Members 9-1-53	Members 9-1-54	Number Delinquent	A.M.A. Non-members
Jackson	18	18	20		6
Jasper-Newton	15	15	19	1	1
Jay	15	14	16		2
Jefferson-Switzerland	26	26	24	3	2
Jennings	9	9	10		5
Johnson	21	21	22		
Knox	42	42	43	2	4
Kosciusko	13	13	9	3	2
LaGrange	9	9	9		
Lake	323	304	328	16	54
LaPorte	78	78	88	3	4
Lawrence	24	24	22		5
Madison	94	91	96	1	5
Marion	939	931	929	15	28
Marshall	22	21	21	2	3
Miami	19	19	21		1
Montgomery	27	26	29		
Morgan	17	17	18		1
Noble	24	24	26		
Orange	13	12	8	4	
Owen-Monroe	56	56	51	2	9
Parke-Vermillion	23	23	22	2	4
Perry	10	10	11		
Pike	8	8	7		
Porter	28	28	29		
Posey	9	9	11	3	1
Pulaski	6	6	6	1	3
Putnam	18	18	17		
Randolph	20	20	21	1	3
Ripley	11	11	13		3
Rush	17	13	18		
St. Joseph	205	203	214	1	1
Scott	4	4	4		
Shelby	22	22	21		
Spencer	7	7	6	5	5
Starke	7	7	7		
Steuben	13	13	14	1	2
Sullivan	17	17	15		2
Tippecanoe	96	95	90	2	2
Tipton	11	11	11		
Vanderburgh	189	186	188	1	6
Vigo	117	117	113	2	
Wabash	25	25	23	1	3
Warrick	8	8	11	1	
Washington	8	7	8		
Wayne-Union	70	67	73	1	8
Wells	27	27	28		
White	8	8	10		
Whitley	10	10	11		
	3,820	3,759*	3,845**	87	227

\* Includes 143 in military service

109—\$10.00 members (residents and interns)

249—senior members

75—members, dues remitted by Council

2—honorary members

\*\* Includes 128 in military service

106—\$10.00 members (residents and interns)

267—senior members

63—members, dues remitted by Council

2—honorary members

## Medical Defense Activities

1. Malpractice cases. A year ago, at the time of this report, August 1, 1953, the following seventeen cases were pending before the committee, seven of which were closed during the year, leaving ten cases still pending:

Case No. 200—Filed February 12, 1932. Pending.

Case No. 251—Filed September 25, 1942. Pending.

Case No. 255—(Closed). Filed September, 1945. Dismissed due to death of defendant.

Case No. 268—Filed September 7, 1948. Pending.

Case No. 269—Filed September 28, 1949. Pending.

Case No. 270—Filed September 28, 1949. Pending.

Case No. 271—(Closed). Filed September 16, 1949. Settled and dismissed, 1954.

Case No. 273—(Closed). Suit settled and dismissed February, 1954.

Case No. 274—Suit filed May 25, 1951. Pending.

Case No. 276—(Closed). Suit filed April 11, 1951. Settled and dismissed, August, 1954.

Case No. 279—Suit filed May 19, 1952. Pending.

Case No. 280—(Closed). Filed March 11, 1948. Case decided in favor of the defendant physician and closed.

Case No. 281—(Closed). Filed May 20, 1952. Settled and dismissed.

Case No. 282—Suit filed August, 1952. Pending.

Case No. 283—Suit filed August 28, 1952. Pending.

Case No. 284—(Closed). Filed June, 1951. Five days' trial in Federal District Court. Verdict for defendant. Expense, \$747.57, paid November 24, 1953.

Case No. 285—Suit filed, October, 1952. Pending.

Since August 1, 1953, and up to August 1, 1954, the following two new cases have come before the committee, neither of which has been closed, making a total of twelve cases pending at the present time as against seventeen unclosed cases at the same time last year:

Case No. 286—Suit filed August 6, 1953. Judgment in U. S. District Court for the defendant. Now pending on appeal.

Case No. 287—Suit filed August, 1954. Pending.

2. Medical Defense Fund Statement, from August 1, 1953, to August 1, 1954:

Balance, August 1, 1953..... \$ 7,764.66

## Receipts:

Dues,

4—1952 members ..... \$ 5.00

122—1953 members ..... 152.50

3,463—1954 members ..... 4,328.75 4,486.25

Interest on bonds ..... 492.60

\$12,743.51



**Disbursements:**

Malpractice fees .....	747.57	
Transfer of interest to General Fund .....	25.00	
Telephone tolls and traveling expenses of attorney .....	29.17	
Salaries, Association attorneys .....	2,890.00	7,691.74
Balance, August 1, 1954 .....		\$ 9,051.77

**Advertising**

Survey of advertising for the first six months of 1954 shows a substantial increase over the preceding six months and over the same period for 1953. (The amount of increase, however, appears to be less in the third quarter.)

Figures on advertising income for the first six months period of the last three years and for the first six months of the current year follow:

State Journal Advertising Bureau	1951	1952	1953	1954
Sold direct by Journal				
Bureau	\$ 9,070.88	\$ 8,134.65	\$ 7,935.62	\$12,435.63
Sold direct by Journal	3,813.82	5,027.65	4,766.60	5,302.22
Total	\$12,884.70	\$13,162.30	\$12,702.22	\$17,737.85

**Printing Cost**

Cost of printing THE JOURNAL shows a continued increase due to the increased size, number of color runs, inserts, etc.; however, there has been no increase in cost of the basic contract with the printer.

Year	Cost	No. of Pages (Inserts Excluded)
1949	\$28,572.41	1,360
1950	\$24,644.07	1,324
1951	\$23,735.75	1,304
1952	\$26,563.85	1,424
1953	\$29,531.61	1,520
1954 (6 months)	\$14,226.22	736

The following table shows the number of JOURNAL pages for the past six years and indicates percentages of reading and advertising material in relation to the totals.

Year	Read- ing	% Read- ing	Adv. Pages	% Adv. Pages	Total Pages	Avg. Pgs. per issue
1948	703	49	707	51	1410	117.5
1949	740	53	652	47	1564	130
1950	690	51	664	49	1354	112.8
1951	674	51	660	49	1334	111.1
1952	845	58	605	42	1450	120.8
1953	960	60	586	40	1546	128.8

JAMES W. DENNY, M.D., *Chairman*

WM. H. HOWARD, M.D.

E. H. CLAUSER, M.D.

W. L. PORTEUS, M.D.

ROY V. MYERS, M.D.

ELTON R. CLARKE, M.D.

**BOARD OF APPEALS ON PATIENT-PHYSICIAN RELATIONS**

The Board respectfully submits to the House of Delegates the following report of its official transactions for 1954.

The Board has held four official meetings since the 1953 session of the Association and will probably meet once more before the 1954 House of Delegates convenes in October.

During the year the Board has had under consideration a total of 15 complaints. One of these cases had been pending before the Board since 1952 and was closed satisfactorily March 14, 1954. Eleven complaints on the Board's 1953 docket are included in this report, and six of these have now been closed.

It is interesting to note that during previous calendar years, 20 complaints were received in 1952 and 18 in 1953. Only two new cases have been received by the Board since January 1, 1954. Perhaps, by providing a Board of Appeals where aggrieved patients can file their complaints in writing, they find they have less to gripe about or write about. Definitely it indicates that sound, ethical, scientific, and humanitarian medical practice prevails in Indiana.

The Board has received no complaints that warranted disciplinary action by the Council and most of the complaints closed by the Board were amicably settled by the physician and the complainant soon after notification of the complaint.

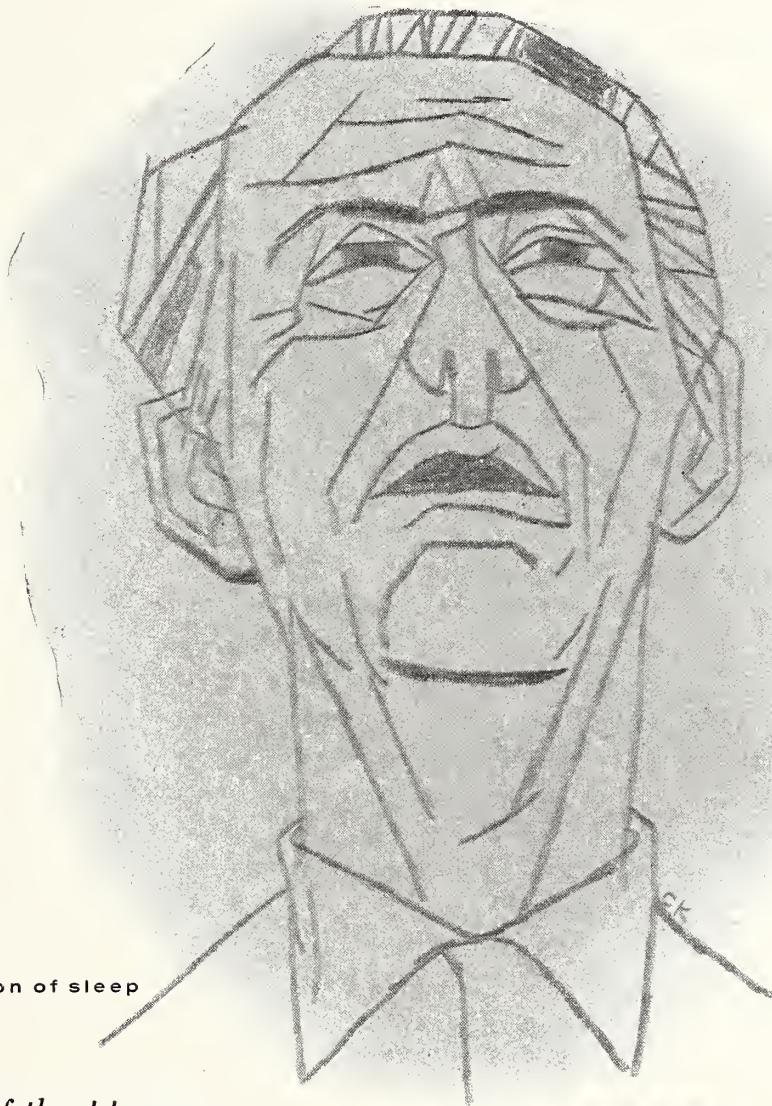
In some instances there would have been no complaint had there been a previous understanding of fees, insurance indemnity, services, and the professional personnel required, before the medical or surgical services were rendered.

The Board has received excellent cooperation from most physicians and the county medical societies but in a few cases settlement has been delayed by failure to receive necessary information requested from the physician to protect his own interests.

The Board is grateful for the brickbats and bouquets it has received from the colleagues in Indiana medicine. The brickbats have been used to make the ISMA structure stronger, and the occasional bouquets have been pleasing interludes in the trying affairs of the Board. With continued cooperation and prompt responses from physicians and county medical societies, the Board hopes to clear its docket of all cases now pending before the 1954 session convenes.

In its 1953 report, The Board stated "That the complaints of the neurotic, the psychopathic and those indoctrinated with the panacea of socialized medicine are its greatest problem", etc.

"These charges, usually absurd, vicious or malicious must be answered or they run rampant in the public square. They injure the reputation of good doctors and are a greater menace to American



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medicine than the few charlatans within our ranks."

The Board then stated "Just how to combat this problem will require time, study and experience."

Continuing its study of this problem, the Board consulted with the President of the Association and presented to the Council the following requests and recommendations.

1. That the President be authorized to appoint a Psychiatrist to serve as a member of the Board until the next session of the House of Delegates.
2. That the House of Delegates amend the By-Laws of the Association to include an accredited psychiatrist as a member of the Board, etc.
3. That the public be frequently informed through a program of paid publicity of the many things the State Association and its component County Medical Societies are doing to serve and protect the health of the public.

These recommendations of the Board were adopted by the Council, the psychiatrist was appointed and has been of valued assistance to the Board.

The Board respectfully requests the House of Delegates to adopt the proposed Amendment to the By-Laws establishing a Psychiatrist as an additional member of the Board of Appeals on Patient-Physician Relations.

Augustus P. Hauss, M.D., *Chairman*  
 Carl H. McCaskey, M.D.  
 Claude S. Black, M.D.  
 Clifford M. Jones, M.D.  
 Harry P. Ross, M.D.  
 William C. Reed, M.D.  
 R. R. Calvert, M.D.  
 R. W. Wilkins, M.D.  
 Paul W. Sparks, M.D.  
 Philip B. Reed, M.D.

## COMMITTEE ON COUNTY MEDICAL SOCIETY OFFICERS' CONFERENCE

The County Medical Society Officers' Conference was held on March 7, 1954, in the Student-Union Building on the I. U. Medical Campus. Approximately 75 physicians were present. The morning session was devoted to a panel discussion entitled "Facing Our Problems". Following lunch, a varied and timely program was presented. Invited speakers included Dr. Frank E. Wilson, Director, A.M.A. Washington Office, Don C. Hawkins, St. Paul Mercury Indemnity Company, J. Wm. Wright, M.D., Eli Goodman, M.D., Arthur P. Tiernan, executive secretary, Vanderburgh County Medical Society,

James A. Waggener, executive secretary, Indiana State Medical Association. A resumé of the proceedings was published in a recent issue of The Journal of The Indiana State Medical Association.

David L. Adler, M.D., *Chairman*  
 V. F. Kling, M.D.  
 E. W. Mericle, M.D.  
 J. E. Dudding, M.D.  
 S. Lewis Stern, M.D.

## COMMITTEE ON CONSTITUTION AND BY-LAWS

The Committee on Constitution and By-laws has had one matter referred to it during the past year and after due study and consideration recommends the adoption of the following amendment to the By-laws of the Association:

"Be It Resolved, that Chapter VIII, Section 1 of the By-laws be amended to read as follows:

*Sec. 1*—the standing committees shall be as follows:

The Executive Committee.  
 Board of Appeals on Patient-Physician Relations.  
 A Committee on Convention Arrangements.  
 A Committee on Conference of County Medical Society Officers.  
 A Committee on Scientific Work  
 A Committee on Scientific Exhibits.  
 A Committee on Public Policy and Legislation.  
 A Committee on Publicity.  
 A Committee on Industrial Health.  
 A Committee on Medical Education and Hospitals.  
 A Committee on Public Relations.  
 A Committee on Constitution and By-laws.  
 A Committee on Rural Health.

The members of such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

In making such elections or appointments next after the effective date of the amendment the terms of such members shall be as follows:

If a committee consists of an even number of members, one-half shall be appointed for two year terms, and one-half shall be appointed for one year terms.

If a committee consists of an odd number of members, the majority by one shall be appointed for two years and the remainder for one year terms.

Thereafter all members shall be appointed for



two year terms. All members shall serve until their successors have been elected or appointed.

BE IT FURTHER RESOLVED, That Chapter IX.—*Special Committees*, be amended to read as follows:

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

The terms of the members of such special committees shall be as heretofore provided for the terms of the members of standing committees.

WM. H. GARNER, M.D., *Chairman*

PAUL D. CRIMM, M.D.

W. HARRY HOWARD, M.D.

W. L. PORTTEUS, M.D.

F. B. MOUNTAIN, M.D.

A. G. BLAZEY, M.D.

## COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health had a luncheon meeting in Louisville with 100 per cent attendance and spent the whole afternoon discussing the work of this Committee. Dr. E. C. Holmblad, Treasurer and Managing Director of the I.M.A. and Dr. John W. G. Hannon from Washington, Pennsylvania were guests.

Several problems were discussed, but the chief topic was the report of our Subcommittee on Silicosis and Pneumoconiosis. Dr. Harcourt is Chairman of the Subcommittee. The discussion was excellent and Dr. Hannon, who is one of the authorities on Silicosis, made several suggestions. The report was then referred back to the Subcommittee for further study. A report is to be made to the full committee in the near future. It is a tough assignment, however, the members are high-powered and capable of handling it.

Another Subcommittee was appointed on Noise in Industry. Dr. Hugh Kuhn is Chairman of this Subcommittee, which is composed of Drs. Carl H. McCaskey, Marlow Manion, J. William Wright, Jr., Robert W. Turgi, David E. Brown, Francis Sondag and Max Steer. Dr. Meyer S. Fox from Milwaukee, and Dr. Aram Glorig from Los Angeles were consultants. They have done a fine job, and their report has been submitted. To date, we have not had time for action by the full committee, but this report can serve as a preliminary report until final passage by the full committee.

The Committee approved the report by the A.M.A. and I.M.A. Committee on the "Guiding Principles of Occupational Medicine" which was presented to the House of Delegates of the A.M.A.

There are many other things we should have done but lack of time seems to have interfered. I am sorry we can't report more, but your Committee has worked faithfully and has been an excellent group.

E. S. JONES, M.D., *Chairman*

RICHARD C. SWAN, M.D.

JOHN W. HILBERT, M.D.

LOUIS W. SPOLYAR, M.D.

EMMETT B. LAMB, M.D.

ALLAN HARCOURT, M.D.

L. S. MCKEEMAN, M.D.

## SUBCOMMITTEE ON SILICOSIS

The subcommittee on Silicosis is composed of Doctors Louis Spolyar, Russell Henry, Chester A. Stayton, Donald Brodie, Raymond Beeler, James Stygall, Harold Ochsner and Allan Harcourt, Convenor. Our committee is concerned with the correct evaluation of Silicosis to the end that the worker in industries with silica exposure will be protected, and secondarily that this condition existing in any individual can be consistently appraised. We decry the wide divergence of medical opinions in testimony in courts and before Industrial Boards and Commissions.

Silicosis may be defined as a chronic condition and fibrosis of the lungs due to the prolonged inhalation of silicon dioxide and characterized by nodular fibrotic change which can be demonstrated by suitable X-ray film and pathological specimens. Silicosis occurs in various degrees of severity and in the severer forms is capable of producing shortness of breath, tightness in the chest, cough, a decreased capacity for work and an increased susceptibility to pulmonary infections.

The diagnosis of Silicosis is dependent upon the following:

- (1) A history of adequate exposure to silicon dioxide.
- (2) An X-ray film of the chest showing abnormal shadows that are compatible with a diagnosis of silicosis and
- (3) Laboratory tests may be employed where there is some question regarding the exposure. These tests are not an indication of disability that may be present; they confirm a history of exposure and may indicate the amount of pathology. They are as follows:
  - (a) Incineration of tissue for evidence of silica,
  - (b) Lung biopsy (the ribs spreading method by which a wedge of pulmonary tissue is removed is more satisfactory than a needle biopsy.)

The following approach in compensation cases is simple and accurate and usually results in con-

clusions that have reasonable scientific accuracy:

- (1) Is there a history of adequate exposure, with particles of silicon dioxide 10 micra or less in size, in excess of five million particles per cubic foot of air for a period of seven or more years.
- (2) Are the X-ray findings compatible with those found in Silicosis. The X-ray interpretation should be made by a competent radiologist Board member versed in lung pathology.
- (3) Are the symptoms those that are found in disabling Silicosis and
- (4) If the subject has a history of adequate silica exposure, positive X-ray findings indicating fibrotic pathology and symptoms of pulmonary dysfunction, then an exhaustive study to make a differential diagnosis of silicosis should be made. Then one should proceed to evaluate the degree of disability by lung function studies, keeping in mind that a decrease in the pulmonary reserve does not necessarily mean a partial disability.

Workers in silicon dioxide contaminated atmosphere should be examined at least once a year, with lung X-rays interpreted by a Board member in X-ray or chest specialist, and an adequate history and physical examination.

It is recognized that tuberculosis and Silicosis are symbiotic. All persons with incipient or active tuberculosis should be removed from the hazard. Persons with adult type healed tuberculosis should be examined at more frequent intervals, and not work in silica dust.

It is the obligation of the examining physician to acquaint applicant with any positive findings of any importance, whether the man is accepted or rejected for employment.

The Committee recommends for standardization of nomenclature in the study of Silicosis, the International Radiological Classification of Pneumoconiosis, a series of chest X-rays, interpreted in agreement by the foremost authorities of England, Canada, France, Belgium, New Zealand, Austria and South Africa, to typify the various stages of pneumoconiosis and silico-tuberculosis. This project was sponsored by the International Labor Organization. Working standard films have been developed and are available from the Pneumoconiosis Research Unit of Medical Research Council of South Wales.

## SUB-COMMITTEE ON NOISE IN INDUSTRY

This Sub-Committee of the Committee on Industrial Health of the Indiana State Medical Association is appointed by Dr. Wm. Harry Howard, President of the Medical Association, and Dr. E. S. Jones, chairman of the Industrial Health Committee, to be advisors to them about the medical and medico-legal implications of industrial hearing losses.

Many matters were brought to the attention of the Sub-Committee for consideration and suggestions to the Industrial Health Committee as to the management of the overall problem of noise in industry. Your Committee discussed the following subjects and our conclusions and recommendations are as follows:

1. Long exposure to intense noise is damaging to hearing. High-pitched sounds are in general more damaging for speech comprehension than low-pitched sounds of the same intensity. Continuous noise is more damaging than recurrent noise of the same intensity. The octave or narrower band analysis rather than a standard sound level meter using only a flat network, yielding only overall intensity levels should be recommended in making an acoustic analysis of noise factors in industrial and manufacturing establishments. A sound level meter with an octave band analyzer should be used to study the composition as well as the level of intensity of industrial noise and should, of course, be used by persons properly trained.

2. Based on the present recommendations of the Sub-Committee on Noise in Industry of the Committee on Conservation of Hearing for the American Academy of Ophthalmology and Otolaryngology and other scientific reports, it is the opinion of your Committee that before a stabilization of hearing occurs that is to differentiate temporary threshold shift from permanent acoustic hearing loss from trauma, an injured person should be away from noisy environment for six months and that repeated examinations at one month intervals for the next three months should determine the loss of hearing for compensation purposes and that these definite periods of time may be altered as continued research in this subject furnishes new information.

3. A Committee of the American Academy of Ophthalmology and Otolaryngology is at the moment doing extensive research on the subject of the importance of certain frequencies for speech determination and we deferred arriving at a definite conclusion about this until this scientific group reports and recommends.

4. It is the opinion of the Committee that the loss of frequencies above 4000 cps are not important as an industrial hearing loss; that a pure tone audiometric test is tentatively the best available



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measurement of the quantity of hearing. Losses of high tones do not interfere with speech communication.

5. This Committee believes that allowance for the aging effect on hearing should be considered and that principles that have been suggested by scientific and analytical groups studying this problem ought to be carried out. (The New York Industrial Commission has adopted the principle that presbycusis is considered to be responsible for one-half of one percent hearing loss for each year that a person is over 50, and that presbycusis is not accepted for normal aging processes below 50.)

6. This Committee recommends that your Industrial Committee encourage and promote a continuing research concerned with the noise problems in Indiana industry and that studies pertaining to acoustic trauma and hearing conservation be carried out; that research be designed to select better tests for choice of personnel who are poor noise risks; that new and better tests be found for the evaluation of acoustic trauma and for evaluating safe noise levels in industry; to design specifications for the control and reduction of equipment noise for the protection of plant personnel; for the general promotion of human and mechanical welfare. Your Committee further recommends that the State Medical Association and your Committee should secure and promote financial support for such research and that a central clearing house for statistical study be encouraged.

7. This Committee strongly recommends that pre-employment hearing examinations as part of a general physical examination be made on all employees in accordance with the following recommendations which were selected from basic material in "A Guide for Conservation of Hearing in Industry" prepared by the Sub-Committee on Noise and Industry of the Committee on Conservation of Hearing for the American Academy of Ophthalmology and Otolaryngology; the Hearing Conservation program for Wisconsin industries; and a consultation of this committee with Dr. Meyer S. Fox of Milwaukee, Wisconsin and Dr. Aram Glorig of Los Angeles, California; a group of Indiana industrial surgeons, medical directors, safety directors, personnel managers, plant engineers and union leaders.

#### Recommendations In Reference To

### HEARING CONSERVATION PROGRAMS FOR INDIANA INDUSTRIES

#### I. Preface

With recognition that loss of hearing can result from exposure to intense industrial noises, Indiana industries are faced with a dual responsibility of obtaining proper measurements of hearing acuity and a maximum protection against hearing loss

due to occupational exposure. At the request of The Industrial Committee of the Indiana State Medical Association the Sub-Committee has set forth in this publication some recommended standards and principles which can be used as a basic guide in providing a hearing conservation program in industry.

In preparing this guide, the Committee is conscious of the fact that it cannot offer a "blue-print" for industry to follow. Local medical resources, the size of the plant and its associated noise problem, and many other factors must enter into a determination of the best program to follow on the local level. All the Committee can do is to point out certain problems and suggest ways by which the welfare of Indiana workers can best be protected against loss of hearing.

This guide is not to be confused with recommendations made by the Industrial Commission of Indiana concerning the basis upon which claims for compensation in reference to hearing disability are based. This is a guide for hearing conservation in industry, with specific reference to screening programs.

Indiana faces this problem as just one of 48 states. National medical and scientific bodies are outlining acceptable procedures and standards for industrial hearing conservation programs, but it has been felt by the Industrial Committee of the Indiana State Medical Association that the development of a state program might be most helpful.

It is hoped that the distribution of this guide will alert industry to its responsibilities and offer avenues through which workable and effective hearing conservation programs can be developed throughout Indiana.

The following pertinent facts related to hearing loss resulting from exposure to intense noise are based upon research and clinical experiences and provide the best knowledge available at the present time.\*

1. Hearing loss caused by noise may be temporary or permanent.
2. Permanent hearing loss caused by noise is due to damage to the inner ear and is not amenable to any known treatment.
3. Noise usually causes more loss of hearing for high-pitched tones than for low tones. In the beginning, most or all of the hearing loss is for tones above those important for the understanding of speech. Therefore, early damage is unnoticed.
4. Noise injures some ears more than others.
5. Apparatus is available to measure hearing loss by pure tone and speech tests.
6. Noise levels which damage the ear can be reduced
  - (1) By engineering methods
  - (2) By ear protection

## II. NOISE PROBLEM AND DETERMINATION OF "DANGER LEVELS"

To what extent noise is intense enough to do damage must be determined by a scientific evaluation of the plant operation. Generally speaking, it can be said that any environment which prevents the hearing of loud conversation at an arm's length suggests the need of further study. In terms of sound measurement it can be said that any environment which has an overall intensity level at or above 90 decibels (as measured on the C scale of a standard calibrated, accepted sound level meter) presents a situation which suggests possible danger of hearing loss to those exposed. There are several means by which industry can evaluate its noise problem through scientific study. Four readily available sources of service are as follows:

1. Industrial Hygiene Division of the Indiana State Board of Health, Indianapolis, Ind.
2. Trained specialists supplied by insurance carriers.
3. Trained acoustical consulting engineers.
4. The Hearing Committee of the Indiana State Medical Association.

Each industry should arrange to have a scientific study of the noise resulting from its own processes, but the following table \*\* will provide a general guide as to noise output of typical industrial processes.

## III. HEARING CONSERVATION PROGRAM

Having determined by scientific studies (see paragraph II) that hazardous noise levels exist

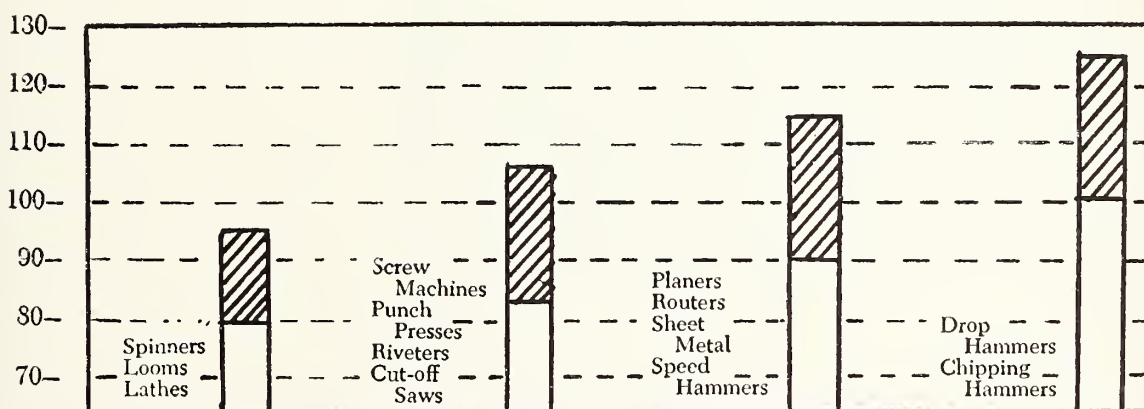
in a plant, one is faced with the problem of protecting the "hearing" of the exposed workers. A good industrial hearing conservation program has one primary objective: to conserve the hearing of workers. Secondary effects are the avoidance of unnecessary economic and social losses and the collection of the facts and data which will enlarge our knowledge of the effects of industrial noise and how they can be overcome.

The pre-employment pure tone audiogram (air conduction), which is a record of the threshold of hearing acuity of the worker at the beginning of his employment, is the base line of the hearing conservation program in industry. This initial record, plus periodic rechecks, enables the supervisory physician to closely follow the hearing status of the worker throughout his employment, to detect changes in hearing ability, and to advise protective measures where indicated. Recommendations on the selection and use of the pure tone audiometer, suggestions for selecting a suitable testing room, types of records to be kept and the need for medical supervision are described in the following paragraphs:

### A. The Audiometer: Its Purpose and Use

The audiometer is an instrument which provides measurements of an individual's hearing acuity to pure tones of varying frequency and intensity. Only air conduction tests are recommended. Only one ear is tested at a time although both ears are covered by the earphones, as a means of reducing the effect of room noise.

A number of audiometers are on the market. It is recommended that audiometers purchased be those which have been approved by the Council on Physical Medicine of the American Medical



Shaded portion indicates range of noise of designated industrial processes

\* American Academy of Ophthalmology and Otolaryngology, Subcommittee on Noise in Industry of the Committee on Conservation of Hearing.

\*\* Aram Glorig, M. D., "Noise in Industry" *Industrial Hygiene Quarterly*, Sept. 1953.



Association. The following is a list of accepted audiometers:\*

### 1. FOR SCREENING PURPOSES

Audivox, Inc. (Successor to Western Electric Hearing Aid Division): 123 Worcester St., Boston 18

Model 4CA (Speech)

Maico Co.: 21 N. 3rd Street, Minneapolis 1, Minnesota

F-1 Standard Audiometer No. 1303 (Puretone)  
Sonotone Corporation: Elmsford, New York

Model 30 and Model 71 (Both Puretone)  
U.S. Recording Co.: 1121 Vermont Avenue, N.W., Washington 5, D.C.

Panacoustic Pure Tone Screening Audiometer,  
Model A-500 (Puretone)  
Microtone A.D.C. Model 53-CI

### 2. FOR DIAGNOSTIC PURPOSES

Audivox, Inc.: Western Electric Audiometer  
Model 6BP and 7B

Maico: Models D-9, E-2, and H-1

\* A current list can be secured by writing to the Council on Physical Medicine and Rehabilitation of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

### B. Who Can Operate the Audiometer?

Determination of the threshold of hearing by the use of the audiometer can be conducted by persons properly trained, provided they are the type who will give careful attention to details in routine testing. They should be trained by or under the supervision of an otologist.

### C. Charts and Records

The pre-employment medical examination record should show the audiometric findings and pertinent items of medical and occupational history which might be related to hearing acuity of the worker. Space should be provided for the recording of otological findings where such examinations are indicated. The audiograms may be recorded as a graph on individual cards usually furnished by the manufacturer of the instrument or on a chart which allows for numerical recordings. See pages 1179 and 1180 for suggested charts which allow for the recording of periodic rechecks on a single page, thereby eliminating bulky files and lost records.

Recheck audiograms may include information concerning current job status, the time of day performed, estimate of time from removal of noisy area, history of intervening ear complaints, and wearing of ear plugs.

The medical history, taken by a physician, or under medical supervision, may have great im-



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portance as a part of the hearing conservation program. Age, previous employment, illnesses with possible bearing on hearing losses, and other related facts may be of significance.

#### D. What Size Industry Should Purchase an Audiometer?

No absolute answer to the above question can be given. Some industries, though small, may have a noise problem affecting most of their employees, which would suggest purchase of equipment for repeated rechecks. Other industries, though large, may have a noise problem affecting a small number of employees. The purchase of equipment which would stand idle most of the time is not realistic.

#### E. Audiometric Test

Recommended test frequencies for pre-placement and periodic audiograms are 250, 500, 1000, 2000, 3000, 4000, 6000 and 8000 cycles per second. Losses in excess of 20 decibels indicate the need for review of the worker's audiogram by an otologist.

Audiograms showing losses in excess of 10 decibels, but not greater than 20 decibels are frequently encountered if testing conditions are not as recommended. Such findings may or may not

be of significance, but audiograms should be repeated.

#### F. Testing Is Not Evaluation

It is emphasized that the interpreting and evaluating of abnormal audiograms is a function of the physician, primarily the otologist, and should not be assumed by nonmedical personnel. Likewise, the mere taking of audiograms without proper interpretation of the "abnormals" by an otologist should not be permitted.

#### G. The Testing Room

Ideally, a testing room should be so isolated from plant operations that its existing noise level does not exceed 50 decibels. Such an ideal is sometimes unattainable, and it is far more important to select the least noisy place in the plant and to proceed with the program than to hold up the development of a testing program. The room provided should be away from outside walls, elevators, heating and plumbing noises, and busy hallways. When compromise with ideal conditions must be reached, the person testing can avoid taking measurements when unusual sounds project themselves into the testing situation.

#### H. Frequency of Periodic Recheck Testing

Every employee who may be exposed to hazardous noise should be tested by use of the audiometer as part of his pre-employment examination.

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Repeat audiograms are necessary in order to detect beginning changes in hearing acuity. These early changes can be recognized only by such tests since the individual may be unaware of any hearing change.

The first recheck audiogram should be made at the beginning of the working day, not more than 30 days after exposure to high noise levels. Whenever feasible it is recommended that the audiogram be taken with a minimum of 48 hours' absence from noise exposure on the job. If possible, rechecks on a Monday morning are desirable. If any change in the worker's hearing acuity is noted as a result of his 30 days' exposure in spite of adequate ear protection, serious consideration must be given to the removal of the individual from the high noise area.

If no significant change in hearing acuity is noted after 30 days, subsequent recheck audiograms should be made approximately every six months.

In all cases of altered hearing acuity not less than three audiograms should be made under similar conditions and at the same time of day before accepting the altered hearing acuity as valid.

#### I. To What Extent Will Protective Equipment Help Medical Supervision?

The use of ear plugs or muffs will provide a great deal of protection, but these are mechanical devices which cannot assure industry that it is giving the worker the maximum protection against ear damage. It is an important avenue through which protection can be achieved, but must not be employed without due regard to many factors which may lessen its effectiveness. Employee resistance to use of protective devices is well known. This resistance may be magnified in respect to the use of ear protectors. However, if deemed essential to the welfare of workers, they should be made the core of an intense educational program directed to employers and employees alike. Many plug type ear protectors, expendable or otherwise, are now on the market. Generally speaking, it can be said that the simple plug which is inserted in the ear is most desirable if properly fitted under medical supervision. These plugs come in assorted sizes, and the employee should wear the largest size which is comfortable and properly occludes the ear canal.

#### IV. MEDICAL AND CONSULTANT SERVICES

The above outline of testing procedures suggests the need for medical and otological services for those employees whose audiometric tests fall below a certain prescribed level. (See E on page 1175) This suggests availability of resources so that proper examination and reports can be made. All physicians in Indiana whose practice is limited to eye, ear, nose and throat (omitting those who

limit their practice to eye alone) will be contacted to determine which of them wish to participate in the Hearing Conservation Program, and all such listed are qualified to assist with the examinations needed for proper medical records and recommendations of placement of workers. Those industries interested in securing lists of physicians who have signified their availability for ear examinations of selected employees can secure same by writing the Chairman of the Industrial Committee of the Indiana State Medical Association, Dr. E. S. Jones, 5231 Hohman Avenue, Hammond, Indiana. Through the agency of the committee preparing this guide, current lists of such physicians will be available annually. To be so listed, the physician must agree to have the proper equipment for use, to be available for appointments requested by industry, and to file the necessary medical reports with the employer.

The fee for such a service cannot be stated except through a determination of the amount of work involved. Individual problems demand individual attention. The only procedure which will prove satisfactory for all parties concerned is to have an understanding among consultants in the area served as to what normal fees will be, and a recognition that individual cases requiring more detailed study will command higher fees for services rendered.

In areas where no consultants are available in the community, special arrangements will have to be made with available personnel in the area. Each industry will have to determine how many employees will need specialized examinations. If few in number, it would be most practical to arrange for individual examination in the physician's office. If large, arrangements might be made to have the consultant visit the community at periodic intervals to conduct examinations for a one or two-day period at a fee which will compensate him for his work and detachment from his regular practice. In communities where there are several small industries, each with a small hearing problem, a cooperative evaluation program might be employed so that a consultant agreeable to the management of all the industries could visit the community at regular intervals and render the service to all employees needing specialized study. Reimbursement and sharing of expenses would have to be worked out through mutual agreement.

#### V. CONCLUSIONS AND SUMMARY

A. Realizing that intense industrial noise as frequently encountered can result in permanent hearing loss to susceptible workers, and with the belief that conservation of human hearing is worth-while, a special Sub-Committee on Noise in Industry of the Industrial Committee of the Indiana State Medical Association offers a practical guide and approach to the problem. The need



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for further education and cooperation of both workers and management is pointed out.

B. Industries having unusually noisy working areas should secure proper evaluation of the existing noise levels in these regions. Scientific studies should be employed. Sources of help have been suggested.

C. The ideal hearing conservation program consists of eliminating or reducing the noise at its source. The extent to which these objectives can be accomplished varies with the machines, the operations and the physical characteristics of the working areas. In areas where the hazardous noise cannot be reduced effectively to "safe-levels," the hearing of workers may be protected by especially designed ear protective devices.

Indiana has been a leader in many programs associated with occupational health. The Committee which has prepared this guide feels certain that employers and employees will cooperate on a program which will give all workers of Indiana industries the best possible protection from hazardous noise. The medical profession recognizes its responsibility in sharing in this program. It is hoped that this guide will be used to establish programs of maximum benefit to all concerned.

The Committee recommends that a standard method of investigating the otological and audiological status of employees be made and uniformly recorded and the following is suggested as a standard method. It is further recommended that these data be compiled and sent to a central statistical unit for analysis and study. There is a need for information and a continuing research program directed to control and initiate improved technics, personnel protection and conservation of hearing in employees.

HUGH A. KUHN, M.D., *Chairman*

DR. FRANCIS SONDAY

DR. MAX STEER

CARL H. MCCASKEY, M.D.

ROBERT W. TURGI, M.D.

RICHARD C. SWAN, M.D.

MARLOW MANION, M.D.

J. WILLIAM WRIGHT, JR., M.D.

DAVID E. BROWN, M.D.

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### Figure 1

## OTOLOGICAL AND AUDIOLOGICAL EXAMINATION

EMPLOYEE: ..... BIRTHDATE ..... AGE: ..... M. S. W. D. - M. P.

NUMBER OF CHILDREN: ..... DATE .....

**OCCUPATIONAL HISTORY:** (Beginning with last previous, and working backward to first job.)

Employer	City & State	Duties	Duration	Noise Exposure
1. ....	.....	.....	.....	.....
2. ....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....
4. ....	.....	.....	.....	.....
5. ....	.....	.....	.....	.....

MILITARY SERVICE: Length . . . . . Branch . . . . . Duties . . . . . Combat . . . . . How Long . . . . .

**MEDICAL HISTORY:** Allergies ..... Dizzines ..... Earaches ..... Frequent Colds .... Head Injuries...

Ringing Ears ..... Running Ears .... Rh. Factor Complications ..... Measles .... Meningitis .....

Mumps ..... Influenza ..... Scarlet Fever ..... Whooping Cough ..... Tuberculosis .....

what other injuries and diseases have you had?

SERIOUS MEDICAL AILMENTS: ..... SURGERY: .....

INDUSTRIAL INJURIES OR DISEASES .....:.....

WORKERS EVALUATION OF HEARING STATUS: Normal ..... Not Normal: ..... Ears: hurt? .....  
ring? .....

Hearing is: Variable ..... Date of onset: ..... Progression of Loss: .....

Has trouble hearing: ..... in groups, ..... in auditoria, ..... in noisy places, ..... Individuals.....

.....at a distance, ..... at close range, ..... on telephone, ..... because of ringing.....

DATE ..... **EXAMINATION**

MOUTH	TONSILS	THROAT	NOSE
<p>1. Color</p> <p>2. Size</p> <p>3. Shape</p> <p>4. Consistency</p> <p>5. Mobility</p> <p>6. Tenderness</p> <p>7. Discharge</p> <p>8. Other</p>	<p>1. Color</p> <p>2. Size</p> <p>3. Shape</p> <p>4. Consistency</p> <p>5. Mobility</p> <p>6. Tenderness</p> <p>7. Discharge</p> <p>8. Other</p>	<p>1. Color</p> <p>2. Size</p> <p>3. Shape</p> <p>4. Consistency</p> <p>5. Mobility</p> <p>6. Tenderness</p> <p>7. Discharge</p> <p>8. Other</p>	<p>1. Color</p> <p>2. Size</p> <p>3. Shape</p> <p>4. Consistency</p> <p>5. Mobility</p> <p>6. Tenderness</p> <p>7. Discharge</p> <p>8. Other</p>

Ear Right Ear Left

Est., Night ..... Est., Day .....

## EXAMINATION

## AUDIOMETRIC FINDINGS

[illegible]

1

**Figure 2**—Sample of an individual record form for recording data related to hearing acuity, designed for use where there is no associated medical history and physical examination record available.

Space is provided for recording pertinent history related to hearing and for serial recording of audiometric tests. The reverse side is used for recommendations by the otologist.





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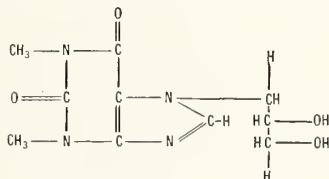
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## COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The past year has been an unusually busy one for the Committee on Medical Education and Hospitals with the growth of the recording loan library and the activities on behalf of the Medical Education Foundation. It is to be reported that the volume of the recording business has grown to such an extent that fast duplicating equipment has been installed in the headquarters office through the courtesy of the Eli Lilly Company who purchased this equipment for the use of the Association. In return for this the Association has been doing some recording work for Eli Lilly Company for their own use and much of it is available through the library for the use of doctors throughout the state.

The committee would also like to call to the attention of the House of Delegates that the American Medical Association is interested in perhaps supplying recordings or making recordings available from the meetings of the American Medical Association and has assigned Mr. Ralph Creer of the Scientific Exhibit Council of the AMA, to come to Indiana and make an investigation of the use of recordings for postgraduate education purposes.

The committee now is able to announce the availability of nearly two hundred hours of scientific recording material and a complete list has been sent to each member of the Indiana State Medical Association.

### MEDICAL EDUCATION FOUNDATION

This year for the first time the national fund's awards to the nation's medical schools will reach more than two million dollars. The grants, totaling \$2,176,904.71 represent a 12 per cent increase over 1953 and bring to just under seven million dollars the total awarded by the fund since 1951 when the first grants were made.

Business corporations contributed \$1,075,326.40 through the fund's committee of American Industry headed by Colby M. Chester of the General Foods Corporation. The balance was contributed by physicians through the American Medical Education Foundation set up by the American Medical Association and the various State Medical Associations.

Accreditation of the University of Puerto Rico School of Medicine in June 1954 brought the number of American Medical Schools to 80—74 four-year schools and 6 two-year basic science schools.

Each four year school received \$15,000 plus \$25 per undergraduate medical student. Each two-year school received \$7,500 plus \$25 per student. Added to these grants were the individual gifts of physicians to designated schools.

The 1954 grant from the national fund to In-

diana University School of Medicine amounted to \$49,367.34, making the total amount received by the school since 1951 \$168,495.34.

Of the above amounts the Indiana State Medical Education Foundation has received from Indiana physicians during the first nine months of 1954 a total of \$21,990.04, making the total collected by our own fund since 1951 \$127,578.24.

While this amount may seem large, the average per member gift is far from sufficient to attain the goal set for Indiana. The committee has underway at the present time a campaign in the hopes Indiana physicians will help to put our state on top of our goal for 1954. As has been pointed out before, this campaign is by necessity a continuing one, and we call this to the attention of this House in the hopes that the House will recommend to the individual physician members and the component county societies that full cooperation be given this effort.

JAMES W. DENNY, M.D., *Chairman*  
H. E. KLEPINGER, M.D.  
JOHN SHIVELY, M.D.  
M. E. GLOCK, M.D.  
RAYMOND J. MODJESKI, M.D.  
EDWIN A. LAWRENCE, M.D.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

The absence of a meeting of the General Assembly this year reduced the activity of the Committee on Public Policy and Legislation to problems on a national level.

Two bills of importance to the medical profession were introduced and were supported by the administration.

1. H.R. 7199, a bill to extend coverage under the Social Security Act to include physicians was strongly urged by the administration and the Department of Health Education and Welfare.
2. H.R. 6950, providing \$40,000,000 over five years for long term loans to assist voluntary, nonprofit health associations to obtain facilities and equipment.

Upon being alerted by Dr. Frank Wilson of the A.M.A. office in Washington, your committee contacted numerous doctors over the state and we are grateful to you for your generous response as evidenced by defeat of those two measures, at least for the present.

HUGH A. KUHN, M.D.  
J. WILLIAM WRIGHT, M.D.  
*Co-chairmen*  
HARRY MURPHY, M.D.  
JOHN M. PARIS, M.D.  
HAROLD J. HALLECK, M.D.  
W. U. KENNEDY, M.D.  
G. O. LARSON, M.D.  
R. B. JONES, M.D.

## COMMITTEE ON PUBLIC RELATIONS

The work of the Committee on Public Relations during the past year has been to carry out the duties assigned it by the House of Delegates and matters referred to it by the Council and Executive Committee throughout the year.

The regular feature of the Committee on Public Relations, namely, the News Flash, has been distributed to members monthly along with other pertinent information of interest to the general membership. Indications are that the News Flash is serving a worthwhile purpose in keeping members of the Association informed on matters of a confidential nature and the committee is of the opinion that the service should be continued during the coming year.

The House of Delegates of the 1953 session approved the report of the Committee on Public Relations and instructed it to prepare a reprint of the booklet on Public Relations for distribution to all members of the association. This has been completed during the past year and it might be well to add that the booklet has received wide recognition from other states and the American Medical Association for its contents.

In conformance with the action of the Council, the Public Relations Committee has been busy developing a radio program which began September 13, 1954, running on every radio station in the state of Indiana for a period of thirteen weeks. The announcements will call attention to the following subjects:

1. Choosing A Physician Before the Need
2. The Emergency Call System Established by the County Medical Societies
3. Discussion of Fees With Your Physician
4. Handling of Grievances

The committee is of the belief that it has carried out its responsibilities and the assignments made it by the various bodies of the Association.

EARL W. MERICLE, M.D., *Chairman*  
KENNETH F. CORPE, M.D.  
HARRY R. STIMSON, M.D.  
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## COMMITTEE ON PUBLICITY

The Committee on Publicity has met regularly through the past year in the headquarters office for the purpose of handling all newspaper releases, radio and television programs.

The "Hints on Health Column," a weekly news release, is currently being used by some 150 newspapers in Indiana and has been continued as have the 15 minute radio programs over Indianapolis Station WFBM. Individual releases on various subjects have been prepared throughout the year. A complete reports follows:

### "HINTS ON HEALTH"

The following is a list of the weekly health columns which appeared in Indiana newspapers and which were prepared by the Committee on Publicity. It is the intent of the committee at all times to supply the public with current and factual information on matters relative to good health.

Flu-Pneumonia	Skin Disorders
That Dangerous Farm	Fresh Air Idiots
Breast Feeding	The Toes' Woes
Health Security	The Road to Ruin
Industrial Health	Motion Sickness
Immunization	Three Score and Ten
Spice of Life	Spots Before Your Eyes
Joint TB	Cleaning Fluid—Dan-
Measles	gerous
Skin Refinishing	See You at Camp
Allergy	Premature Babies
Frost-Bite	How's Business?
Fire Safety	Rabies
Watch That Chest	Drive Carefully
Soap Irritation	New Drugs
Age and Its Changes	Emotional Significance
Teen-Age Dangers	of Injury
It's a Slippery Trail	Busted Beezer
New Blood for Babies	Sight—Protect It
Prevent Mental Illness	Psoriasis—Skin Dis-
Crossed Eyes	order
It's Safer to Kiss a Pig	Lye—A Dangerous
Drug Addiction	Caustic
Health Examinations	Gallstones
Sprains Are Not Simple	Home Sweet Home—
Sore Mouth	Beware
Relax	Let's Face It
Pesticides	What Did You Say?
Your Glands	Cataracts
Kidney Stones	Fever

### GENERAL NEWS RELEASES

In addition to the weekly health column the following general releases were sent to the press of Indiana during the past year:

General story on the annual convention  
Fifty Year Club Membership story  
Story of The Medical Auxiliary

Physician of the Year Story  
Out of State Speakers Story

### RADIO PROGRAMS

Radio Station WFBM has continued to carry the regular 15 minute program each week and the committee has selected those released by the American Medical Association currently upon their release for this program.

J. O. RITCHEY, M.D., *Chairman*  
ROY A. GEIDER, M.D.  
D. S. MEGENHARDT, M.D.

## COMMITTEE ON RURAL HEALTH

The Committee on Rural Health has busied itself during the past year in continuing the activities started in previous years and in re-evaluating the program of the committee as to the public relations value to the association.

The committee has continued to conduct the placement service for physicians in Indiana and is happy to report that during the first nine months of 1954 a total of 197 new physicians located within the state of Indiana.

While the committee cannot take sole credit for this increase in physicians in the state of Indiana we do feel from the demand placed upon the placement service that it has had a bearing upon new physicians locating within the state.

In addition to the placement service for physicians the committee has instituted during the past year, a monthly bulletin to all communities who are seeking the services of a physician. In this bulletin names of all physicians inquiring about locations, their addresses and the type of practice they prefer to do is sent to the community with the suggestion that they contact these physicians and invite them to visit the community and talk to the leaders about locating in that area.

The committee has also, through its chairman, Dr. Joseph Dudding, talked to the medical students during the medical school class year on the subject of locating and practicing in rural communities.

The committee is happy to report that the recommendation made by it last year to the House of Delegates that the Health Forum Series take the place of the Regional and Rural Health Conferences has met with a fair degree of success in the state. Several counties have held the Health Forums and many have plans for conducting these forums during the coming months.

We believe that this is a very valuable facet in the total public relations program in organized medicine and sincerely recommend that this House urge each county medical society to consider this for the respective communities for the coming year.

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Perhaps one of the most outstanding activities of the committee during the past year was the holding of Senior Class Day at which time the committee was host to all the senior medical students and their wives for an afternoon program and a dinner. On Saturday afternoon, May 1, 1954, at the Columbia Club, Indianapolis, the program for this meeting with Dr. Bert Ellis as toastmaster, was as follows:

2:00 p.m.—Registration.

2:25 p.m.—Greetings were extended by President Wm. Harry Howard, M.D., to all those in attendance.

Following that Dr. William Paynter of Pekin, graduate of the class of 1952 of Indiana University, spoke on "The Mechanics of Setting Up A Practice," followed by Mrs. Robert Seibel of Nashville who talked on the subject "With Your Apron On or Off." This was a discussion of the physician's wife's role in his practice in a small rural community. A question period followed when many of the students asked questions of Doctor Paynter and Mrs. Seibel about life in a rural area and the practice of medicine in such a community.

Next Dr. Eli Goodman of Charlestown, a member of the committee, spoke on the subject of "Urban vs. Rural Practice," and Doctor Dudding of Hope, spoke on the subject of "Public Relations for the General Practitioner in the Rural Community," followed by the executive secretary of the Indiana State Medical Association who discussed "What Is Organized Medicine?"

"The Role of the Physician's Wife in the Practice of Medicine" and the part the Auxiliary plays in Association affairs was discussed by Mrs. Harry C. Harvey of Fort Wayne, president of the Auxiliary to the Indiana State Medical Association. Pierre de Tarnowsky of Mead Johnson and Company of Evansville spoke on "Postgraduate Education on Legs," explaining the part the detail man plays in keeping the physician well informed. This was followed by Dr. Walter L. Portteus of Franklin, secretary of the Indiana Blue Shield Plan who talked on "How to Get Paid and Like It." A second question period followed. The group adjourned at 5:30 p.m., for a social hour, courtesy of Mead Johnson and Company of Evansville. Dinner, courtesy of the Blue Shield Plan of Indiana, was served in the ballroom.

The committee felt it was very fortunate in obtaining the services of Mrs. Charles Sewell of Otterbein who spoke at dinner on "They Also Serve" and delivered an outstanding talk for the closing session of the day.

The committee is happy to call to the attention of this House of Delegates that this program was put on without any expense to the Indiana State Medical Association, the firm of Mead Johnson and Company of Evansville acting as host for the cocktail party and the Indiana Blue Shield Plan picking up the check for the dinners.

The committee would like to recommend in view of its experiences that this be made an annual affair and sometime early in 1955 it is felt that both the junior and senior class and their wives should be invited to a similar program and thereafter begin working with the junior class rather than waiting until the senior year for these programs.

Comments from the medical students were that this was one of the most worthwhile programs they had attended and the enthusiasm was great as well as interest in the subject of practice in smaller communities of the state. It is felt this was one of the finest gestures made on the part of organized medicine for young physicians and we feel much good was gained by them in having better knowledge of organized medicine and practice in Indiana communities. We, therefore, recommend to this House and in turn recommend to the succeeding committee that this event be staged again in 1955 for both the senior and junior classes.

The committee has met with Aubrey Gates, field representative of the Council on Rural Health of the American Medical Association, and discussed many problems existing between organized medicine and the rural groups. As a result of this the committee will hold a meeting with representatives of the Farm Bureau and the Extension Service of Purdue University to find ways and means of integrating the activities of the Rural Health Committee more closely with those of these rural organizations.

It is also to be reported that as a result of the recommendation made by this committee last year and the activity of the Executive Committee and the Council in following through with the action of the House of Delegates, the Medical Registration Board has adopted a regulation to make it easier for eligible physicians to begin practice in the state of Indiana.

J. E. DUDDING, M.D., *Chairman*

JOHN M. BRETZ, M.D.

LOUIS E. HOW, M.D.

W. G. PIPPENGER, M.D.

RALPH C. EADES, M.D.

ELI GOODMAN, M.D.



## SUB-COMMITTEE ON PRECEPTORSHIPS

The Preceptorship Committee has been very active this past year. Numerous articles have appeared in the State Medical JOURNAL relative to the Preceptor program. On January 13, 1954, Doctors Dudding, Voyles, VanNuys, and Bibler, presented a panel discussion for the Junior and Senior classes of the Indiana University School of Medicine.

On April 12, 1954, the Committee entertained the Council of the Indiana University School of Medicine. Dr. Grey Dimond, University of Kansas School of Medicine, was the guest speaker.

May 12, 1954, a Committee meeting was held at the Student-Union building in Indianapolis. There is considerable interest among medical students in Preceptorship training and it is recommended that this House of Delegates recommend to the Council of the Indiana University School of Medicine that credit be given to all students who participate in Preceptorship Training of thirty days or more. Fifty-two Doctors of Medicine have volunteered to act as preceptors in this program. Seven medical students are participating in the Preceptorship program at this time.

LESTER D. BIBLER, *Chairman*

HARRY E. VOYLES, M.D.

JOSEPH DUDDING, M.D.

JOHN VANNUYS, M.D.

JAMES DENNY, M.D.

## ALCOHOLICS STUDY COMMITTEE

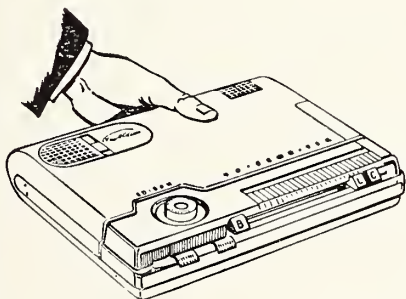
The Committee on Alcoholism held a meeting at the Columbia Club on June 20, 1954. The Committee invited as guests, John Payton, Chairman of the Indiana Commission on Alcoholism, and Dean L. Barnhart, Director of Education and Rehabilitation.

There was a general discussion of the problem of alcoholism and all were in agreement that there should be close cooperation between the Committee on Alcoholism of the Indiana State Medical Association and the Indiana Commission on Alcoholism. Our Committee felt that we could serve a useful function in an advisory capacity to the Commission. Further, the Committee felt that we might be of assistance in implementing the program of the Commission at the county level by Committees on Alcoholism in each county medical society.

Our Committee believes that alcoholism is a disease that has many facets in its etiology, some of which are known and others unknown. We feel that a solution lies in the cooperation of all specialties in medicine, the most important being the psychiatric. We hope to encourage research study of this problem in Indiana University School of Medicine, and would like to see physiochemical and endocrine studies done on alcoholics to see if these fields can shed any light on this problem.

We recommend that the present Act concerning alcoholics be amended to provide that at least two members of the Commission shall be persons

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licensed to practice medicine in Indiana. In addition, we feel that a definite percent of money received by the liquor control commission be set aside as an Alcoholics Commission fund. This will enable the Commission to be assured of a definite amount of money. At the present no definite amount is provided. Further, we recommend that the Act be amended as to commitment. At the present, commitment must be on a voluntary basis. We feel that any court should be able to commit to the custody and control of the Commission, for a period of not more than three years, any habitual alcoholic.

The present Act on Alcoholism is the result of a bill drawn up by Mr. Albert Stump, attorney for the Indiana State Medical Association. The Indiana State Medical Association has had an active part in starting a program for the treatment and rehabilitation of persons addicted to the intemperate use of spirituous or intoxicating liquors. Your Committee feels that it is important that our Association continues to take the lead in dealing with this problem and that the program not be controlled by well meaning, but poorly qualified individuals.

LOWELL F. BEGGS, M.D., *Chairman*  
DONALD W. BRODIE, M.D.  
PHILIP B. REED, M.D.  
HARRY BRANDMAN, M.D.  
F. B. MOUNTAIN, M.D.

## COMMITTEE ON ANTI-NATIONAL HEALTH INSURANCE

The Committee on Anti-National Health Insurance had nothing referred to it during the year and therefore the committee has no report at this time.

CLEON A. NAFE, M.D., *Chairman*  
W. U. KENNEDY, M.D.  
RAY ELLEDGE, M.D.  
ALFRED ELLISON, M.D.  
PAUL D. CRIMM, M.D.

## AUDITING COMMITTEE

The annual meeting of the Auditing Committee was held on July 15, 1954, at the Indiana National Bank, Indianapolis. The investments of the Association were examined in detail and are listed below:

### General Fund:

United States Savings Bonds, Series G__	\$ 46,000.00
United States Savings Bonds, Series K__	55,000.00
United States Treasury Bonds-----	65,000.00
	<hr/>
	\$166,000.00

### Medical Defense Fund:

United States Savings Bonds, Series G__	\$ 13,000.00
United States Savings Bonds, Series K__	1,000.00
United States Treasury Bonds-----	5,000.00
	<hr/>
	\$ 19,000.00

Bank statements of cash balances, as of June 30, 1954, in the Indiana National Bank, the American National Bank, the Fletcher Trust Company, and the Bankers Trust Company were examined by the committee. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund, and the Petty Cash Fund, respectively, and showed the following balances:

General Fund -----	\$ 89,261.32
Medical Defense Fund -----	9,449.68
THE JOURNAL Fund -----	16,564.97
Petty Cash Fund -----	307.17
	<hr/>
	\$115,583.14

ELTON R. CLARKE, M.D., *Chairman*  
ROY V. MYERS, M.D.  
JOHN R. BRAYTON, M.D.  
BERT E. ELLIS, M.D.  
E. B. HAGGARD, M.D.

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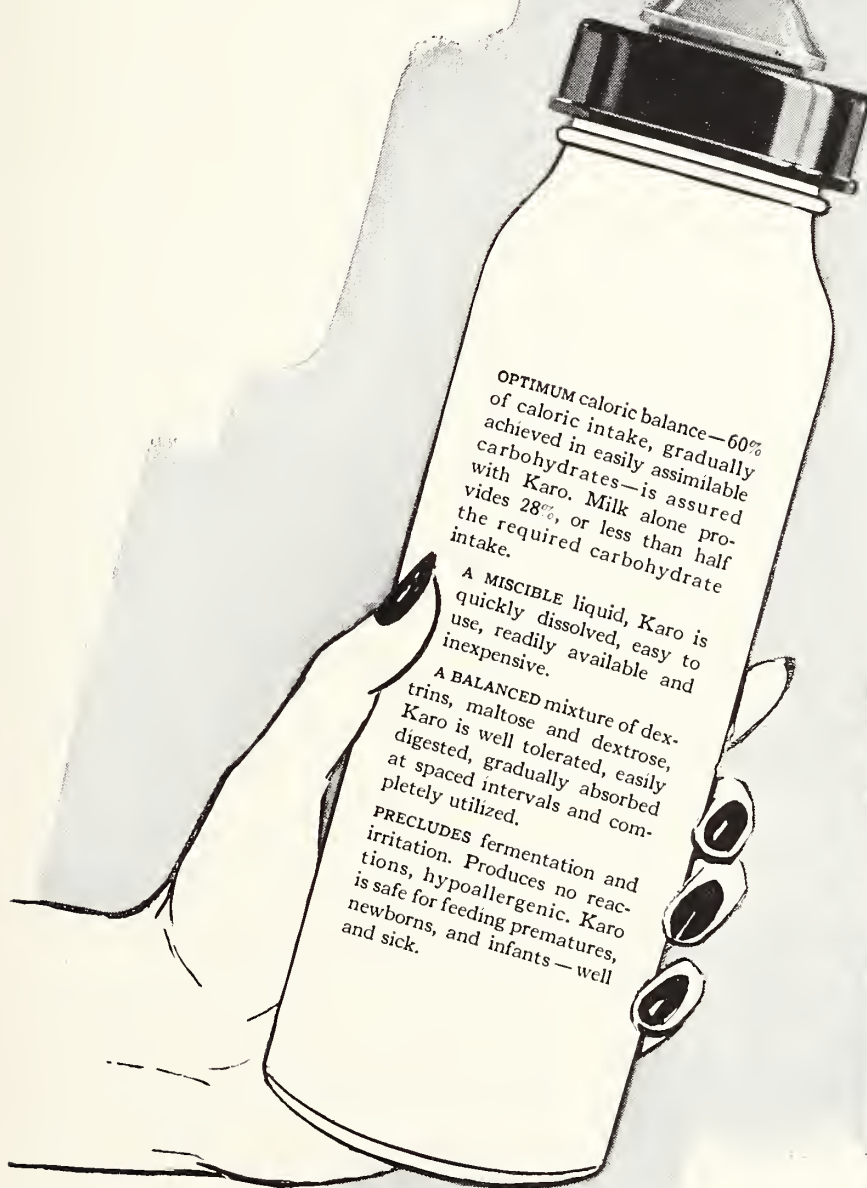
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## COMMITTEE ON CANCER

We believe that the present propaganda on cancer control is dangerous to the reputation of physicians and a great hindrance to the wise treatment of cancer because it has created both an undue fear of cancer and expectations of cure which cannot be fulfilled. We believe also that the good of the public and of our profession will be promoted by consideration of the following facts:

1. The all-out war waged on cancer for the last 30 years has not decreased the cancer death rate.

2. The dictum, early cancer is curable cancer, must be greatly qualified. It is what the people have been taught—in fact about all they have been taught—about cancer control. It provides a plausible explanation for the failure of operation to cure cancer. Cancer propagandists will think it wicked to question its validity, but this needs to be done. It is, of course, true for non-metastasizing tumors, but it has been well established that the results of early operation for more malignant growths are statistically worse than those of later operation. The more rapidly spreading growths are more likely to be discovered sooner, treated sooner and, despite early treatment, to kill sooner than those which spread more slowly. We must not conclude from this that early diagnosis and treatment are not commendable. Early operation for the individual patient may be better than later operation, but it is not so much better as it has been thought to be. Bear in mind that it has not lowered the cancer death rate.

3. The frenzied effort to discover preclinical cancer should be controlled. Its results are often tragic. No treatment should be given before the diagnosis has been established beyond reasonable doubt. Major operations to prevent cancer are never justifiable.

4. The extremely radical and prolonged operations being done in many "cancer centers" have been tried and found wanting. They have been done on the assumption that "any worth while operation for cancer must be designed to accomplish its total removal." They have been justified neither by their results, which are deplorable, nor by what we know about how cancer spreads in the human body. This makes it highly improbable that the extirpation of disseminated cancer can ever be achieved by operation. The advocates of these radical operations take it for certain that cancer spreads almost entirely by way of lymph vessels. We know now that the more malignant growths spread by way of the blood vessels also, probably in all cases. Length of survival after operation for widespread cancer certainly depends more on bodily resistance to its growth than on its total removal.

5. Cancer Research is of two kinds:

a. Fundamental—this is an inquiry into the causes of tumor growth; into how the body regulates the multiplication of its every cell to the advantage of its every other cell. Neoplasia occurs when this regulation is absent or defective. Ignorance about this matter is still profound. Perhaps the most important discovery in this field is that the sex hormones influence the growth of cancers of the breast and prostate.

b. Clinical—This includes study of the diagnosis of cancer, of its natural course when untreated, of the effects of treatment on its natural course and of its possible causes—hereditary and environmental.

The mere statement of the foregoing obvious facts is sufficient to dispel many popular notions about cancer research, and to indicate the magnitude of the problem this seeks to solve. It is evident that treatment is best governed by clinical experience. This has taught us that some cancers can be cured, that some can be kept quiescent for various lengths of time and that some are uncontrollable by any means we now possess.

6. Lay interference with medical practice in the diagnosis and treatment of cancer has done great harm. The medical profession should take control of informing the people on cancer, and should tell them the unvarnished truth about it. This will strengthen their faith in our honesty and it cannot make them fear cancer more than they fear it now.

We doubt the wisdom of such practices as teaching women the self diagnosis of breast cancer and of teaching school children about cancer. Finally, we believe that a competent family doctor is very well able to direct the diagnostic study and treatment of cancer. Experience has qualified him to prevent what ought not to be done to a cancer patient.

W. D. GATCH, M.D., *Chairman*

NICHOLAS EGNATZ, M.D.

NORVAL E. GREEN, M.D.

W. W. NAHRWOLD, M.D.

CLYDE G. CULBERTSON, M.D.

## COMMITTEE ON CHRONIC ILLNESS

The Chronic Illness Committee of the Indiana State Medical Association, met on August 11, 1954, at the Student Union Building, Indianapolis.

The first item on the agenda for the meeting, was a review of the problem of chronic illness as outlined by the 1953 committee. The 1954 committee reaffirmed the basic objectives, as outlined by the 1953 committee, and voted its approval.

Since chronic illness is largely a problem of the local community, the committee recommends that each County Medical Society make a study of the

# VAGINAL ANATOMY AND CONCEPTION CONTROL

Another observation based on  
425 patient years of exposure

According to a recent comparative study by Guttmacher and co-workers,<sup>1</sup> vaginal anatomy and parity apparently play important roles in the selection of a contraceptive method. Using the jelly-alone method, they found that markedly greater protection was afforded to women of low parity, and suggested that the jelly "might be confined to the region of the external os more successfully in the less relaxed vagina."

Of 325 women who used the jelly-alone [RAMSES® VAGINAL JELLY] technic for periods ranging from three months to three years, 36 percent were primiparous. The statistically valid data, based on 425 patient years of exposure, definitely indicate that the jelly-alone method of contraception was considerably more effective "among patients of lower parity."

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The total unplanned pregnancy rate averaged only 16.7 per 100 patient years of exposure. If method failures alone

are calculated, the unplanned pregnancy rate was reduced to 10.82 per 100 patient years of exposure.

It is apparent from this study that RAMSES VAGINAL JELLY is markedly effective in the jelly-alone technic, and that it is a "method of choice" for most nulliparous and primiparous patients.

Anatomic considerations, however, should not be the sole criteria used in the selection of a contraceptive method. Such factors as patient intelligence and cooperation, as well as the sincere desire for conception control, are also of paramount importance. Thus, the choice of method must, in the end, depend upon the physician's evaluation of the individual patient.

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425 EXPOSURE YEARS	425 EXPOSURE YEARS
TOTAL FAILURE RATE	METHOD FAILURE RATE
16.7	10.82

Effectiveness of RAMSES VAGINAL JELLY as contraceptive measure in 325 patients during 425 patient exposure years<sup>1</sup>

\*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

1. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: *Am. J. Obst. & Gynec.* 63:664, Mar., 1952.

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problem, in order that facilities in each community may be provided for the care of the chronically ill. The local medical societies should encourage the enlargement of facilities already in existence. It is preferable that facilities for the care of the chronically ill be added to general hospitals which can provide laboratory and X-ray facilities, as well as provisions for nursing care, laundry, eating, etc.

A discussion of the Hill-Burton Bill was entered into. As of this date the Senate has approved about 35 million dollars additional for the new Hill-Burton hospital construction program, to finance clinics, rehabilitation centers, chronic disease hospitals and nursing homes.

The committee recommends that the Governor of the State of Indiana appoint a committee consisting of representatives from different social groups, to study the problem of chronic illness, especially with reference to the allocation of funds as provided in this bill. This committee should also study the best way to set up provisions for the care of the chronically ill in local communities and the possibility of building a chronic disease research hospital, to be located on the Indianapolis Campus of the Indiana University School of Medicine.

The problem of rehabilitation of persons convalescing from chronic illness, and those beyond the age of retirement, at 65 years, was discussed. While Indiana population has doubled since 1900, that segment of population beyond 65 years of age, has quadrupled. With retirement, either voluntary or required, at age 65, many of these aged people, who are very capable mentally and very able physically, have no further objectives in life. The committee recommends that a program of rehabilitation should be created to provide employment for this group of our population.

The Indiana State Board of Health saw fit to establish a department of Gerontology and chronic diseases in 19 . The committee commends this action on the part of the State Board of Health and hereby extends its approval of this act.

Two very extensive surveys, one dealing with County homes for indigents and one dealing with nursing homes for the care of the chronically ill, were reviewed. The maintenance of County Poor Farms in many communities has become very expensive. It was the opinion of the committee that they were not adaptable to the care of the chron-

ically ill and that their use for this purpose should not be recommended.

The committee was impressed by the amount of improvement as shown in the report for the provision of better general care for the chronically ill, which nursing homes have made in the past two or three years. The committee recommends that the Indiana State Medical Association express its opinion of this improvement in nursing homes to the Indiana Association of Licensed Nursing Homes.

Screening processes to discover different types of chronic illness were discussed. The committee expresses its approval of such procedure where there is no doubt as to the efficiency of the test to be employed. Audiometer tests for hearing, Snellen's tests for vision, various tests to reveal the presence of sugar and albumen in the urine, as well as miniature X-rays of the chest to reveal pulmonary pathology and blood pressure determinations were approved by the committee.

Since the incidence of pulmonary tuberculosis has been shown to be 4 or 5 times greater in general hospital admissions, than it is in the general population, the committee recommends that all general hospitals require routine chest X-rays of all admissions to discover pulmonary pathology.

The committee recognizes that tuberculosis is a communicable disease which can be a serious health hazard to the individual as well as the community and that various laws pertaining to quarantine and isolation have been passed by the state Legislature.

However, since carcinoma of the lung and various types of cardiac pathology are often suggested by the miniature X-ray films, the committee recommends that in all case-finding programs, regardless of who conducts the program, where suspicious findings of any kind are present:

- (1) That the person be sent a notice informing him that he has suspicious findings in his lungs. The exact type of disease need not be mentioned, and
- (2) That the person having the X-ray be sent to his family doctor for a final diagnosis.

To follow such a plan will bring the patient to his own doctor regardless of whether his findings are suspicious of tuberculosis, cardiac, or other pulmonary pathology.

F. R. NICHOLAS CARTER, M.D. *Chairman*

C. O. ALMQUIST, M.D.

DAVID B. SILBERT, M.D.

DAVID D. OAK, M.D.

E. C. SINGER, M.D.

A. L. HICKMAN, M.D.



## COMMITTEE ON CIVIL DEFENSE

1954 has been the greatest year of activity for Civil Defense that we have had in the state of Indiana. This has been due to the statewide cooperation in the exercise called "Operation Alert," which was held June 14 and 15, and which was part of a national exercise to test Civil Defense Organization, statewide communications and medical organized preparedness. In our preparation to participate in this national exercise of "Operation Alert," it was necessary to make a survey of the organization and preparedness of the medical branch of the Health Services Division in each county in the state.

The result of this survey was very heartening and showed that a reasonable state of advancement in Civil Defense preparedness has been accomplished in practically every county in the state of Indiana. Furthermore, the replies to these inquiries showed a willingness to participate and to proceed further with Civil Defense preparedness throughout the state.

For the purposes of the "Test," it was assumed that Allen County and Marion County would be targets of atomic bombing in the state of Indiana and that the state would attempt to meet these assumed bombed target situations by theoretically sending supplies and medical personnel to the assistance of the bombed areas, and at the same time to prepare throughout the state for hospitals to receive casualties from the target areas and to care for them in the ratio of five times the existing bed capacity of local general hospitals.

All counties did not participate in this exercise due, sometimes, to the failure of other branches of Civil Defense to be organized, or willing or capable of participation. However, in those counties which did participate, excellent cooperation was received from the County Health Services directors. Except in the two target areas, namely: Fort Wayne and Indianapolis and in some of their automatic or mutual aid counties, that is those counties immediately surrounding these target areas, no attempt was made to actually mobilize or move medical personnel or supplies.

Going back to the survey made before this exercise was carried out, a few instances were found where Medical Civil Defense has not been kept up. For example: In Ripley County, it was discovered that the county health services director had retired from practice and has been living in Florida for the past two years. In one or two instances, the replies from the county health services directors would suggest that the men who have been picked for this job were unfortunate selections and that other more interested individuals should be found to fill these assignments.

We consider that we have five major target areas in the state of Indiana. These are: Lake County, South Bend, Fort Wayne, Indianapolis and Evansville. Since each of these areas started

its Civil Defense organization long before state plans for organization were available to them, it is only natural that their local plans vary somewhat from those that are now being suggested for county Civil Defense organization. However, Civil Defense does not contemplate being a "dictatorial organization" and counties may organize as they see fit to meet the Civil Defense situation that could develop within their own home community. But in making the survey for the "Operation Alert," it was found that even our target areas are not as well organized as would appear advisable for the good of the individual community and for the state as a whole. For example: South Bend has plans for only four first aid stations, which is entirely out of proportion to the probable need for this city. Deficiency in planning also showed up in other major target areas, which only serves to point up the need for continuing interest and development of our Medical Civil Defense organization in order to be adequately prepared for any eventuality in the state.

Another step forward in Civil Defense preparedness has been the final completion of the assembling of materials to go into first aid kits and the distribution of these first aid kits to the major target areas of the state, plus distribution to other counties on a matching funds basis where funds have been forthcoming from these local communities.

The state Civil Defense organization is materially hampered in its ability to distribute more information to the Health and Medical Services Divisions throughout the state, due to the marked limitations of funds available for such purposes.

Recently, there has been a move through the Adjutant General's office to organize a State Securities Force which has been visualized as taking over the Civil Defense organization of the state. This contemplated organization would be similar to the State Guard, which was in existence in Indiana during World War II. The Committee is making a further investigation of this matter and plans to make a supplemental report upon this situation during the State Convention.

GLEN WARD LEE, M.D. *Chairman*

L. E. BURNEY, M.D.

R. G. HUSTED, M.D.

G. A. McDOWELL, M.D.

M. C. TOPPING, M.D.

## COMMITTEE ON CONSERVATION OF VISION

Upon the approval of the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association and also the Indiana Academy of Ophthalmology and Otolaryngology, it was agreed that representatives from these two bodies should meet with representatives of the Indiana

Optometric Association and the Indiana Association of Opticians for the purpose of resolving common problems. This organization has been active for the past year and is known as the Indiana Inter-Professional Committee on Eye Care. Indiana is the twelfth state in the Union to form such an Interprofessional Committee. In addition, there is representation on the Indiana Committee from the National Society for the Prevention of Blindness and ex-officio members comprised of a representative of the Indiana State Board of Health, the head of the department of the Indiana University Division of Optometry, and a representative of the Indiana University Department of Ophthalmology.

Such an inter-professional committee has been found to be very satisfactory in the discharge of visual problems as they apply to the entire state.

At present, five salient purposes have been outlined for accomplishment by this inter-professional committee.

- (1) Encouragement of ethical educational advertising only, approved by this committee.
- (2) Encouragement of legislation, prohibiting physicians from accepting employment by commercial optical companies.
- (3) Aid to industry and checking safety lenses and goggles.
- (4) Establishment of standards for first-quality spectacle lenses of all kinds.
- (5) Visual screening of school children.

At the present time, this inter-professional committee has had two meetings and the following subjects have been under consideration but no final decisions or implementation of the objectives have as yet been accomplished.

- (1) A bill is under consideration for presentation to the State Legislature for licensing dispensing opticians.
- (2) State-wide visual examination of school and pre-school children.
- (3) Ethical educational advertising only.
- (4) Aid to industry on standards of safety lenses and goggles.
- (5) Requirements for motorists' visual testing.

It has been found most convenient for the Conservation of Vision Committee to discharge its duties through this inter-professional council and it seems likely that in the future, much can be accomplished towards the betterment of eye care and eye health in the state through this medium. However, it is to be noted that upon matters of major importance as they may affect the medical profession as a whole in the state of Indiana, the representatives on this council from the Indiana State Medical Association are bound not to make any final

decisions until they are brought before the House of Delegates of the Indiana State Medical Association, and approved by this body.

E. W. DYAR, M.D., *Chairman*  
 JOHN M. MASTERS, M.D.  
 CARL J. RUDOLPH, M.D.  
 M. RICHARD HARDING, M.D.  
 FRANK H. COBLE, M.D.  
 D. S. KORANSKY, M.D.

## COMMITTEE ON CRIPPLED CHILDREN SERVICES

A meeting of the Committee on Crippled Children Services was held in Indianapolis on May 23, 1954.

### Members Present:

LEO K. COOPER, M.D., *Gary, Chairman*  
 GORDON W. BATMAN, M.D., *Indianapolis*  
 FRANK M. HALL, M.D., *Indianapolis*  
 HENRY J. ROSEVEAR, M.D., *Hammond*  
 NORVAL E. GREEN, M.D., *South Bend*

**Dr. Middleton Presents Plan For a Domiciliary Facility For Crippled Children.** Dr. Thomas O Middleton, pediatrician of Bloomington, met with the committee and presented a plan which originated with the Bloomington Exchange Club and Indiana University. This plan would provide a suitable structure for housing and a responsible agency for the general care of physically handicapped or deficient children, on or adjacent to the campus of Indiana University.

The purpose of providing domiciliary care for these children is purely educational and is not designed to include treatment. The object is to train teachers to recognize, deal with, and teach mentally deficient and physically handicapped children. These children are to be referred by physicians and other agencies throughout the state for care periods of one scholastic year.

Dr. Middleton is seeking the sanction of the Indiana State Medical Association for establishing this domiciliary facility. He stated that the Exchange Club of Bloomington has been assured by the University of its backing of this project.

**Available Funds For Project.** It is proposed that a Foundation be established by the various Exchange Clubs throughout the state to raise funds, establish the facility outlined above, provide continuing support and control of said facility, and attend to the welfare and needs of the personnel involved. Funds presently utilized for care of the children receiving training at the Speech and Hearing Clinic of Indiana University will be available to this Foundation, which will, in effect, replace the wholly inadequate facilities now in use. Support will also be derived from private and



public agencies, individuals, and Exchange Clubs throughout the state of Indiana.

**Recommendation Governing Extent of Care.** Dr. Frank M. Hall recommended that very definite lines of responsibility be established in order to distinguish between the care of these children while at the University and the treatment of the child's defects.

Dr. Hall also stated the necessity of limiting the proposed clinic in its medical function and limiting the types of cases accepted to those for which the clinic was originally planned. Cases to include those of blindness, deafness, mentally retarded and other types of physically handicapped whose conditions can be improved.

Dr. Gordon Batman recommended that a physician be on the Executive Board of this children's facility as well as educators and lay members.

**Approval of Proposed Plan.** This committee unanimously expressed its interest and approval of the above proposed plan as defined by Dr. Middleton, and respectfully recommends to the Executive Board of the Indiana State Medical Association that the project for caring for handicapped children for educational purposes is sound.

**Investigation of Agencies For Caring For Crippled Children.** Dr. Gordon Batman recommended that this committee go on record as favoring the investigation of all the various ways and agencies through which fee for service is taken care of in the treatment of crippled children; and he recommended that, if possible, ways of caring for children be simplified.

LEO K. COOPER, M.D., *Chairman*

GORDON W. BATMAN, M.D.

FRANK M. HALL, M.D.

NORVAL E. GREEN, M.D.

HENRY J. ROSEVEAR, M.D.

## COMMITTEE ON DIABETES

During the 1953 Diabetes Detection Drive the St. Louis Dreyapak was used in addition to urine testing. The Dreyapak, being a strip which can be dipped in urine and dried for collection, was well accepted by the public. A total of 23,028 tests were made in Indiana during the drive.

The American Diabetes Association is preparing 1,500 Dreypaks for free distribution to each county society participating in the 1954 drive. Amounts in excess of this number will be charged at the rate of not over 2c each for the complete unit assembled. Revisions have been made on the Dreyapak itself, including the name of the patient's physician on the reverse side of the strip, and a double purpose envelope has been devised which will enable the testee to read the instruction sheet printed on the inside flap of the envelope. The envelope will also be used to mail the Dreyapak to

the testing station, and in cases where notification of the results is desired, the testing station, by tearing off a section of the envelope, can notify the testee of the results of the test.

Plans are being made to interest each county medical society in the conduct of a Diabetic Drive during Diabetes Week, November 14-20. The 1954 drive represents an inspiring challenge to every society since approximately six times greater coverage can be accomplished with Drey-paks than with the testing of urine samples collected in liquid form. Each society is urged to complete its distribution of Drey-paks one week in advance of Diabetes Week in order that the testee may have the strip during the week of intensive publicity.

D. D. DICKSON, M.D., *Chairman*

SAM ADAIR, M.D.

JOHN H. WARVEL, M. D.

L. F. GWALTNEY, M.D.

CASPER HARSTAD, M.D.

## COMMITTEE ON HARD OF HEARING

This committee wishes to bring to your attention:

1. That all problems related to hearing difficulties should be referred to this committee for their consideration and study. That the committee be composed of four otologists, two industrial physicians, and one general practitioner of medicine. When any special problem arises, there should be a sub-committee appointed from the Conservation of Hearing Committee to study the problem and make a report on it.

2. That the school systems continue their study of the hearing problem of the school children and report the same to the proper authorities. When a hearing problem is discovered, it should be called to the attention of the child's family physician, and the case should be referred to a competent otologist who should report his findings in the case and recommend the proper treatment.

3. That a hearing commission should be set up composed of five members to be made up as follows: two otologists, a teacher of the deaf, the Superintendent of Public Instruction of the State of Indiana, and the Director of the Health Department of the State. A bill should be proposed to the legislature at the next session to make this legal.

4. That there is a law in effect in many states at the present time which provides for the care of hard of hearing handicapped children. This law should be studied and strengthened if necessary.

5. That a brochure should be prepared and published in THE JOURNAL of the Indiana State Medical Association so that all the members of this Association may understand the nature and extent



of the work which is being carried out by the various groups working with the conservation of hearing.

6. That rehabilitation of those having hearing loss is a tremendous problem. This in many instances is a matter of education.

7. That there are many organizations working on the problem of the hard of hearing. The following are a few that should be mentioned, and there should be a liaison with each:

The League for the Hard of Hearing  
 The Educational Institutions of the State  
 The Otolaryngological Department of the Indiana University School of Medicine  
 The State Board of Health  
 The Otolaryngological organizations both on the state level as well as the national level  
 The Audiology Foundation  
 The State Superintendent of Public Instruction  
 The Indiana School for the Deaf

8. That one of the important phases of conservation of hearing is the relation of hearing loss to noise exposure. This is a problem which has received much consideration from various groups, such as the Sub-committee of the American Academy of Ophthalmology and Otolaryngology, The Acoustical Society of America, and The American Standards Association. One of the problems in carrying on these various phases of research has

been a financial one, but at the present time this is beginning to be surmounted as industry begins to be awakened to the fact that numbers of suits have been filed charging that noise has been the cause of the plaintiff's loss of hearing. Of course investigators should not allow themselves to be biased toward either industry or labor. There has not been any measure set up officially which is satisfactory to be used as a standard for the percentage of measurement of hearing loss due to noise. If such a standard should be set up, then legislation could be enacted which would set up a compensation for such loss of hearing. The Conservation of Hearing Committee should advise the State Legislature and the State Board of Health of the need of a specialized group available to industry for their information and guidance in the control of industrial noise and its effect on personnel.

9. Wisconsin has set up a guide which was prepared by the sub-committee on noise in industry of the Committee on Conservation of Hearing for the American Academy of Ophthalmology and Otolaryngology. The following are pertinent facts based upon research:

- a. Hearing loss caused by noise may be temporary or permanent.
- b. Permanent hearing loss caused by noise is due to damage to the inner ear and is not amenable to any known treatment.

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 W. N. WRIGHT, M.D. Resident Psychiatrist  
 HENRY GRUENER, M.D. Resident Physician  
 ELLIOTT OTTE.....Business Administrator

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c. Noise usually causes more loss of hearing for high pitched tones than for low tones. In the beginning, most of all of the hearing loss is for tones above those important for the understanding of speech. Therefore, early damage is unnoticed.

d. Noise injures some ears more than others.

e. Apparatus is available to measure hearing loss by pure tone and speech tests; not the percentage of loss.

f. Noise levels which damage the ear can be reduced by: a. Engineering methods, b. Ear protection.

10. One problem, that of otosclerosis, has been made less trying. This is a type of hearing difficulty which occurs in young individuals. This type of deafness is caused by a benign bony growth which causes fixation of the stapes thereby interfering with the transmission of sound waves to the internal ear. When this condition occurs there are only two types of treatment which give hope of improvement of hearing. One is the wearing of a suitable hearing aid, and the other is the fenestration operation. The cases for this operation should be well selected and when suitable the results of the operation in restoring hearing are remarkable. Therefore, when such cases are encountered by physicians they should be told of these two possibilities for the rehabilitation of their hearing. Not all of these cases are suitable for surgery.

11. We must give credit where credit belongs, and a great deal has been accomplished by the Department of Speech and Hearing of the four educational institutions which are state supported; i.e., Indiana University, Purdue University, Indiana State Teachers College, and Ball State Teachers College. The public school systems in many places have been instrumental in their efforts to discover the hard of hearing in their institutions.

12. That we would be remiss if we did not give hearing aids their proper place in the rehabilitation of those with hearing loss, but not all persons can get results from wearing hearing aids. One hearing aid may be more satisfactory to one person, and another type more useful to others. At the Audiology and Speech Clinic at Indiana University Medical Center they have many varieties of officially recognized hearing aids of different makes and the one is selected which is best suited to each person's particular hearing loss. The cases which come to this clinic must be referred by an otologist who has done otological and audiometric assessments of the patient.

13. This committee has been in existence for a number of years and recommendations are made each year. As otologists let us become active and see what can be done in the way of helping work out some of these problems or at least make the

hard of hearing problems one of our major projects.

We respectfully submit the foregoing for your consideration.

CARL H. McCASKEY, M.D., *Chairman*  
MARLOW MANION, M.D.  
J. WILLIAM WRIGHT, JR., M.D.  
ROBERT W. TURGI, M.D.  
DAVID E. BROWN, M.D.

## COMMITTEE ON HEART DISEASE

The Chairman of the Committee on Heart Disease contacted the other members of the Committee for suggestions of an active program that might be initiated on the program of heart disease in Indiana.

We all agreed that since the Indiana Heart Foundation is doing such a remarkable job and has outlined a very extensive program that the best interests of the Medical Association would be for this Committee to concur and cooperate with their efforts. I wish to inform you that this is being done.

GEORGE M. COOK, M.D., *Chairman*  
W. S. FISHER, M.D.  
GEORGE S. BOND, M.D.  
HARRY P. ROSS, M.D.  
DONALD E. WOOD, M.D.

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## INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

No Report

### COMMITTEE ON INSTRUCTIONAL COURSES

Your Instructional Course Committee met in Indianapolis May 12, 1954. Preparations for this meeting had been made by considerable correspondence between the members and the chairman. Six of nine members were present.

It was the unanimous decision of the committee that the schedule of courses developed by past experience should obtain for the 1954 session. This provides for 30 courses, presented in blocks of six courses, given simultaneously, and at hourly intervals, beginning at 11 a.m. Monday, October 25.

In selecting subjects for presentation your Committee gave due consideration to those topics requested or suggested by our members. In consequence, almost half of the topics selected for presentation this year represent "request subjects".

It was very gratifying to your Committee that every person selected as an instructor accepted his assignment most willingly.

We trust the program as prepared will be most helpful and instructive.

FRANK FORRY, M.D., *Chairman*

E. A. LAWRENCE, M.D.

FRANK H. COBLE, M.D.

HARRIS B. SHUMACKER, M.D.

DAVID A. BICKEL, M.D.

EMANUEL MARCUS, M.D.

RICHARD M. NAY, M.D.

HEDWIG S. KUHN, M.D.

### COMMITTEE ON MATERNAL AND CHILD HEALTH

This Committee met three times during the year; every member of the Committee attended at least one meeting. The activities of this Committee were in cooperation with the Division of Maternal and Child Health of the Indiana State Board of Health. The matters pertaining to Maternal and Child Health which were considered were as follows:

1. The recommendation of the previous Committee concerning the Brown County Maternity Service was approved.
2. As previous Committees have done for several years, the establishment of a premature center at the Indiana University Medical Center was recommended. Dr. Ly-

man T. Meiks, Chairman of the Department of Pediatrics of the Indiana University School of Medicine, met with the Committee and discussed the establishment of a premature center. The establishment of such a center has been considered for several years, but such a project is not feasible at the present time because extensive remodeling at Riley Hospital would be required, and also a sufficient number of nurses trained in premature care are not presently available.

3. Material on premature care which was prepared by the previous Committee, in conjunction with the Division of Maternal and Child Health of the Indiana State Board of Health, has been distributed to every hospital with a department of obstetrics, and to the secretary of every local medical society.
4. At the request of the Director of Health Service of the Indiana Department of Civil Defense, the Committee made recommendations for the care of premature infants in case of an atomic attack. Handicapped by unfamiliarity, the Committee could make only a few simple suggestions; such as emergency methods of applying heat and oxygen to premature infants. If heat is applied by hot water bottles, bricks, etc., extreme caution must be exercised to prevent burning. Ventilation must be provided for improvised incubators (baskets or cardboard boxes). If medical oxygen is not available, commercial, or welder's oxygen, may be safely used. Measures for the protection of babies from radiation should be obtained from Civil Defense Committees.
5. The Committee recommended publication in THE JOURNAL of statistics pertaining to stillbirths and cesarean section incidence from 1950 to 1952 inclusive.
6. The institution of a Maternal Mortality survey in Indiana, such as is now being carried on in more than twenty states, was approved, and Dr. C. O. McCormick, Sr., was appointed to make such recommendation to the Section of Obstetrics and Gynecology of the Indiana State Medical Association to obtain approval of the House of Delegates.
7. The Committee manifested definite interest in the speech and hearing center at the Indiana University Medical Center. Dr. Francis L. Sondag, director of the clinic, met with the Committee and outlined the work which is now being carried on, and the extent of the program which is being planned for in the future. At the present time, because of limited specially trained personnel in this field, the center is unable to take care of all individuals in the state with remediable



speech or hearing defects. The center is now operating to the limit of its working capacity to care for patients, and is assisting local speech and hearing therapists, physicians, school administrators, and nurses and is providing in-service training for therapists who are locally employed in this field.

8. Consideration was given to the establishment of a premature center at the Northern Indiana Children's Hospital.

It was recommended that a Committee be appointed to contact the medical societies and general hospitals in this locality, and determine the feasibility of establishing such a center.

9. Throughout the year, Dr. Jeanne Rybolt has reported some of the new programs of the Division of Maternal and Child Health of the Indiana State Board of Health. Some of these projects include:

A Vision Screening Survey in cooperation with the Indiana Interprofessional Committee on Eye Care and the Indiana State Department of Public Instruction. The purpose of this survey is to standardize recommendations to be made to every school system in the state. New Incubator loan centers have been established in Richmond and Washing-

ton. Dr. Mitchell has assisted other staff members in the administration of polio vaccine trials. The Division has cooperated with the State School for the Blind and other interested individuals in establishing conferences for parents of preschool blind children.

10. This Committee wishes to express its sincere appreciation to Dr. Jeanne Rybolt, Director of the Division of Maternal and Child Health of the State Board of Health, for her cooperation and invaluable assistance throughout the year. Also the Committee deeply regrets that she is retiring from this position July 1, 1955. Her successor will be Dr. Howard W. Mitchell, who has recently returned from service with the U. S. Public Health Service in Iran. During the next year, Dr. Mitchell will attend the University of Michigan and obtain a Master's degree in Public Health.

DAVID A. BICKEL, M.D., *Chairman*

C. O. MCCORMICK, SR., M.D.

R. S. SCOTT, M.D.

HENRY W. EGGERS, M.D.

MAHLON F. MILLER, M.D.

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## COMMITTEE ON MEDICAL CARE INSURANCE

In discussing the matters pertinent to the responsibilities of your Committee on Medical Care Insurance, it was brought out that a problem existed in obtaining proper representation of the physicians of a given medical district on the Board of the Blue Shield Plan.

Originally the board was established following a special meeting of the House of Delegates, which authorized the establishment of the Blue Shield Plan, and which authorized the President with the approval of the Council to appoint the original Board.

Since that time, it has been the policy of the Plan to notify the Association of the expiration date of the members of the Blue Shield Plan board and the Council has either recommended reappointment or made suggestions as to replacements. There has been some feeling that members of the district should have the privilege of making nominations for membership on the Board inasmuch as it is desirable that each Councilor district have on the board, a representative physician from its area.

Your committee discussed the method of selection and replacement of members of the Blue Shield Board, and is of the opinion that the nomination for appointment or election to the Blue Shield Board should become a matter for each Councilor district to handle as a matter of business during their regular Councilor district meetings.

Therefore, your committee recommends that this House of Delegates approve the following, and that a copy of this action be formally transmitted to the Blue Shield Plan.

The House of Delegates of the Indiana State Medical Association, meeting in Indianapolis, October 24, and 27, 1954, desires to make the following recommendation to the Indiana Blue Shield Plan, under provisions established wherein the Association has the right to make such suggestions concerning the election of directors of Mutual Medical Insurance, Inc.

1. That effective immediately, all future nominations made for physician membership on the Board of Directors of Mutual Medical Insurance, Inc., The Blue Shield Plan, shall be made by the respective Councilor district from which the member is to be selected.
2. That Mutual Medical Insurance, Inc., notify the secretary of each Councilor district of the name of the physician now representing the district and the date of expiration of his term of office.
3. That the notification to the secretary of the Councilor district, also request that the dis-

trict at its next meeting, prior to the expiration date of the term of office, nominate a physician who is an active member of the Indiana State Medical Association for its representative on said Board. It is to be understood that under this proposal a district would have the right to nominate a member to succeed himself as a member of the Board.

WM. C. REED, M.D., *Chairman*  
H. M. ENGLISH, M.D.  
GUY B. INGWELL, M.D.  
O. O. ALEXANDER, M.D.  
K. L. OLSON, M.D.  
O. M. GRAVES, M.D.

## COMMITTEE ON MENTAL HEALTH

No Report

## COMMITTEE ON MILITARY MANPOWER

The activities of the Military Manpower Committee during the past year came to almost a complete standstill with the change in military needs and the reduction of medical personnel to three per thousand troops. Those doctors commissioned a year ago had their call to active duty deferred until this coming Fall.

So far as records permitted, the doctors in priority I and II, who were classified 1A, were screened as to essentiality and availability.

Further calls by the Armed Services on Selective Service for more doctors began July 1, and three calls have almost completely depleted the list of physicians in the priorities they have designated to meet their requirements before the current extension of the Doctors Draft Law expires. Unless Selective Service re-classifies the few remaining doctors deferred, it is difficult to foresee any further calls on Indiana.

During the year, more physicians who have served in the Armed Forces have returned to the state than are likely to enter the Armed Forces.

While position essentiality is still recognized, both availability of replacements and directives from the National Advisory Committee advising against further deferment in priorities at present subject to call will prevent any deferments in the lower priority.

JOHN OWEN, M.D., *Chairman*  
JOHN PALM, M.D.  
G. A. THOMAS, M.D.  
H. M. ENGLISH, M.D.  
WM. COCKRUM, M.D.  
ERWIN BLACKBURN, M.D.  
GAYLE H. HUNT, M.D.  
CARL G. MILLER, M.D.

## COMMITTEE ON NECROLOGY

It is the purpose of the Committee on Necrology to report each year the deaths and causes of deaths of all Indiana physicians. This report has been duly made for 1953 and filed with the State Association for publication in THE JOURNAL of the Indiana State Medical Association.

JAMES B. MAPLE, M.D., *Chairman*

J. R. FRANK, M.D.

FRANK FORRY, M.D.

## COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION

No Report

## COMMITTEE ON STATE FAIR

The Committee on State Fair had a large exhibit during the 1954 Indiana State Fair located in the west building of the State Board of Health Building, occupying some 40 feet of wall space. The exhibit featured two exhibits of the American Medical Association. One exhibit was on reducing, explaining the caloric values of various foods, and the other was on insecticide poisoning.

The committee conducted the usual free blood pressure examination tests and as usual was busy throughout the fair making these examinations.

The committee desires to express its appreciation to the Auxiliary for its help in supplying hostesses for the booth during the fair and it should be called to the attention of the House of Delegates that the women also distributed literature on behalf of the medical association and offered subscriptions to TODAY'S HEALTH Magazine.

MALCOLM O. SCAMAHORN, M.D., *Chairman*

ROY V. PEARCE, M.D.

H. E. BIBLER, M.D.

J. E. DUKES, M.D.

JOHN D. COONS, M.D.

## COMMITTEE ON TRAFFIC SAFETY

There have been no committee meetings of the Traffic Safety group and no communications that required special attention so there is nothing to report.

O. L. MARKS, M.D., *Chairman*

ROBERT RANG, M.D.

R. K. WEBSTER, M.D.

R. W. LAVENGOOD, M.D.

J. W. CRAIN, M.D.

## COMMITTEE ON TUBERCULOSIS

### Recommendations

This Committee recommends that case finding be emphasized among groups of people who have the highest incidence of tuberculosis. Furthermore, when other groups of people are X-rayed routinely, the yield of active and inactive cases always should warrant the cost of service. For example: To date, a higher incidence of tuberculosis is to be found in all admissions to general hospitals, in inmates of mental hospitals, penal institutions, nursing homes and infirmaries, and among food handlers including restaurants, tavern and drug store employees. Until these groups are X-rayed annually, other groups of people can be checked sufficiently through the regular channels of medical practice.

We recommend that the Indiana State TB Association or any county association or groups of county associations be loaned the mobile X-ray units of the State Board of Health if these associations desire to finance and operate them. We believe that Federal subsidy for such operation is undesirable.

The Committee was in agreement that the following regulation concerning passes for patients is impracticable and should be left to the discretion of the attending physicians and superintendents of TB hospitals: "Passes from tuberculosis sanatoria or hospitals shall be restricted to individuals with a negative sputum; except in extenuating circumstances, such as a death in the family, serious illness in the family, an acute financial problem needing the patient's presence to resolve or other emergency, the superintendent may authorize a pass for a positive sputum case.

"In the positive sputum case, care shall be taken to assure that children under 15 years of age will not be in the home during the visit. The pass should be limited to overnight. Written permission from the local health officers shall be obtained by the patient for any pass extending beyond overnight. Under no circumstances shall the pass extend beyond 72 hours. Infectious cases may transfer from their hospital to their home only on written approval of the local health officer."

In view of the fact that the declining death rate, the increased efficiency of tuberculosis control and the marked progress of antibiotic therapy enable a patient to arrest tuberculosis in a shorter length of time, the need for extra beds, as evidenced by empty beds in most of our institutions, presents no problem. The average patient can complete his cure at home. Arrangements should be made to distribute patients to those sanatoria which have empty beds.

We recommend to the Indiana State TB Association and the National TB Association that the overlapping of organizations and objectives is a waste of time, money and energy; that the pro-



gram expansion committees be requested not to waste their time and our money on such non-productive fields as socio-economic, nutritional and psychological factors which occur in any program in any community; and that their objective be confined to the education of the public regarding tuberculosis and its control, including case-finding and follow-up. Furthermore, the National TB Association should cooperate with the National Cancer Society and the National Heart Association to the extent that all three groups educate the public regarding tuberculosis, cancer and heart disease. An X-ray program of case-finding should find and follow up tuberculosis, cancer and heart disease. A combined effort on the part of these organizations would be a forward step in the public health field and of great financial economy to the average taxpayer and contributor.

The Committee also recommends to the Indiana State Medical Association and the Indiana State TB Association that they request the National TB Association and any other national organizations interested in economy and efficiency to withdraw funds from the support of the National Health Council. We believe that any national organization interested in health education is qualified to carry on without supporting an overlapping group such as the National Health Council. If a coordinating body is necessary, it can be developed by each organization's representatives meeting annually to discuss their mutual problems. We believe it a travesty on the sincerity of people who finance each organization to spend their money for such an organization as the National Health Council.

The National Health Council was reorganized in 1948 for the purpose of coordinating the functions of its member agencies. It desires to relate the elements in the programs of member agencies that are of common concern, through more inter-agency staff meetings, through conferences called to consider special problems or opportunities, and through inter-agency memoranda, bulletins and

news letters. In addition, the Council promises to see that the work of its members proceeds in harmony with the activities of such groups as the Inter-Association Committee on Health, Commission on Chronic Illness, National Social Welfare Assembly, Commission on Financing Hospital Care, and the Commission on the Health Needs of the Nation.

The American Cancer Society and the American Medical Association are to be congratulated for withdrawing their support. May other participating agencies who are acting as Santa Claus to the National Health Council rally sufficient intestinal fortitude to withdraw their financial support!

PAUL D. CRIMM, M.D., *Chairman*

JAS. H. STYGALL, M.D.

PHILIP H. BECKER, M.D.

H. B. PIRKLE, M.D.

D. F. STONE, M.D.

R. C. MEYER, M.D.

## VENEREAL DISEASE COMMITTEE

The Venereal Disease Committee of the Indiana State Medical Association, in conjunction with the Indiana State Board of Health, has reviewed the venereal disease situation in Indiana, from 1943 through 1954, and has reached the following conclusions:

1. The committee desires to endorse the use of the private laboratory by practicing physicians for the examination of blood specimens for serological determination of syphilis.
2. While all states of syphilis have markedly declined in Indiana, gonorrhea still presents a problem. The treatment of gonorrhea also presents a problem in that the patient who



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might have been infected with both GC and syphilis may have syphilis masked by treatment adequate for gonorrhea but inadequate to cure early luetic infection.

3. The trend in the cost to the taxpayer in venereal disease control is revealed by the following figures:

	Fiscal 1943-44	Fiscal 1953-54
State Funds	0	88,300*
Federal Funds	234,764	11,196
Local Funds	77,551	70,430
Total	\$312,315	\$169,926*

\*The VD investigators and technicians in the serology laboratory are included in this sum from the State appropriation for venereal disease control.

4. Through the efforts of the private physician, the Indiana State Medical Association and public health officials, Indiana has controlled venereal disease to the point that the state's position is quite favorable when compared with some of our sister states and other areas of the United States.

5. The ratio of three to four cases of early latent syphilis reported to each case of primary and secondary syphilis indicates:

- a. Failure of diagnosis of recent years or insufficient treatment of early syphilis.
- b. Failure of prophylactic treatment because of insufficient dosage of drug used.
- c. Many cases of early syphilis are masked by treatment of acute gonorrhea with sufficient drug to cure gonorrhea but not to cure early syphilis.

6. There has been a marked decrease in the number of cases of congenital syphilis and infant mortality due to syphilis reported annually. In this connection, however, too many of the reported cases of congenital syphilis are in a higher age bracket where treatment is difficult.

7. Physicians are reporting prenatal serology on birth certificates extremely well so far as the state as a whole is concerned. There are counties in the state, however, where reporting is very lax in this regard.

In consideration of the above facts, the Venereal Disease Committee of the Indiana State Medical Association makes the following recommendations:

1. Physicians treating venereal disease are invited to refer to proposed dosage of anti-

biotics for the various stages of syphilis and gonorrhea as recommended by this committee and distributed through the Division of Communicable Disease Control of the Indiana State Board of Health.

2. Physicians are urged to use every means possible in obtaining prenatal serology in every pregnancy about the fourth month. It is realized that many patients are not seen until delivery. In this case, blood should be obtained at the time of delivery or during postpartum care.

3. Physicians are urged to report all cases of venereal disease. No patient will be contacted in any manner by the State Board of Health representatives unless specifically requested by the attending physician. Physicians interested in the reasons for reporting and the procedure in regard to contact investigations, please refer to the material mailed from the Indiana State Board of Health.

Material in regard to venereal disease problems in Indiana was presented by Doctor Marshall to the committee for consideration. This material included a review of the venereal disease problem in Indiana, a suggested treatment schedule for venereal disease as recommended by this committee, observation of patients with false or questionable serology, graphs on the incidence of disease in Indiana as compared with the United States, and information in regard to reporting and contact investigations.

The above material was discussed by the committee and recommendations made for the modification of the treatment schedule and additions thereto. It was suggested by Doctor Marshall that the material might be duplicated and distributed from the Division of Communicable Disease Control of the Indiana State Board of Health, providing such a plan was approved by the committee.

A motion was made by Doctor Marshall, seconded by Doctor Mercer and carried unanimously, that the material as submitted be approved for distribution to physicians of the Indiana State Medical Association.

Material as above approved is to be duplicated by the State Board of Health and distributed to all physicians prior to the Indiana State Medical Association meeting in Indianapolis, October 25, 26 and 27, 1954.

FRANK M. GASTINEAU, M.D., *Chairman*

A. L. MARSHALL, JR., M.D.

JAMES E. ENGELER, M.D.

SAMUEL R. MERCER, M.D.

WILLIAM E. SUTTON, M.D.



## COMMITTEE ON VETERANS AFFAIRS AND REHABILITATION

The Veterans Affairs Committee was not called due to two reasons,

- (1) The American Medical Association called a meeting to outline their policy. This policy was not accepted by all physicians.
- (2) The Interprofessional Committee has been working along the same lines as our Committee.

I\* personally felt the only thing we should do was to go along with the policy of the A.M.A. They should be supported when they have taken a definite stand on a definite problem.

The same fee schedule was signed after consulting the Council.

WM. H. GARNER, M.D., *Chairman\**  
W. M. STOUT, M.D.  
WM. B. CHALLMAN, M.D.  
B. W. CHIDLAW, M.D.  
RALPH EVERLY, M.D.  
DAN E. TALBOTT, M.D.

## LIAISON COMMITTEE WITH LABOR

This committee had had no meeting during the year and therefore has nothing to report at this time.

R. L. KLEINDORFER, M.D., *Chairman*  
LESTER D. BIBLER, M.D.  
RAYMOND E. NELSON, M.D.  
ARTHUR J. ROSER, M.D.  
WALTER L. PORTTEUS, M.D.  
WM. HARRY HOWARD, M.D.

## LIAISON COMMITTEE WITH THE INDIANA ASSOCIATION OF LICENSED NURSING HOMES

Dr. Paul Iske and your chairman met twice with a committee from the Nursing Homes Association, and agreed to support a questionnaire to be submitted to the doctors of the state for suggestions as to improvement in nursing homes, equipment, and personnel, with the idea of standardizing them.

The Nursing Home Association is eager to cooperate with the medical profession and we heartily recommend a continuance of this friendly relationship.

J. WILLIAM WRIGHT SR., M.D., *Chairman*  
PAUL G. ISKE, M.D.  
CLEON A. NAFE, M.D.

## THE JOURNAL

The staff of THE JOURNAL is glad to report that the past 12 months of publication have been characterized by financial solvency and editorial success.

The annual report of the Executive Committee contains details of advertising revenue and expenses, and also deals with the special issues during the past year.

We have been fortunate in receiving an adequate number of well-written and timely scientific papers. These, together with the Annual Convention papers which are suitable for publication, and with the special articles which are written on request, have constituted a body of medical literature sufficient for the twelve issues. We now have on hand a backlog of accepted papers large enough to allow time for processing, but not so large as to unduly delay their publication.

Modernization of the format and printing details is a continuous process. Numerous minor improvements have been made in this respect during this year and several other changes are being planned for the future.

Special information features such as the "Physician Placement Service" which lists opportunities and requests for medical practice locations have been added. "Opinions from Here and There" has been continued. A special report from the A. M. A. Washington office is airmailed to THE JOURNAL on the ninth of each month and is published under the title "The Month in Washington". This has replaced "AMA Washington Office News" in an effort to report this news in as fresh a condition as possible.

THE JOURNAL was able to reproduce the designs for a rural doctor's office which resulted from a competition jointly sponsored by the Indiana Society of Architects and the I.S.M.A. This has been a feature which was well received and produced much favorable comment.

Publication of THE JOURNAL is an endeavor which requires and receives the support of all the members of the Association. The editor wishes to call attention to the splendid work done by the editorial and business staff of THE JOURNAL, and to acknowledge the interest and cooperation of the many individual members who have responded to requests for advice and assistance during the past year.

FRANK B. RAMSEY, M.D., *Editor*



## AMENDMENT TO CONSTITUTION CONCERNING ELECTION OF A COUNCILOR IN EVENT OF A VACANCY

To Be Voted on at the  
Indianapolis Session, 1954

At the 1953 annual convention at French Lick, the House of Delegates adopted the following report of the Reference Committee on Amendments to the Constitution and Bylaws:

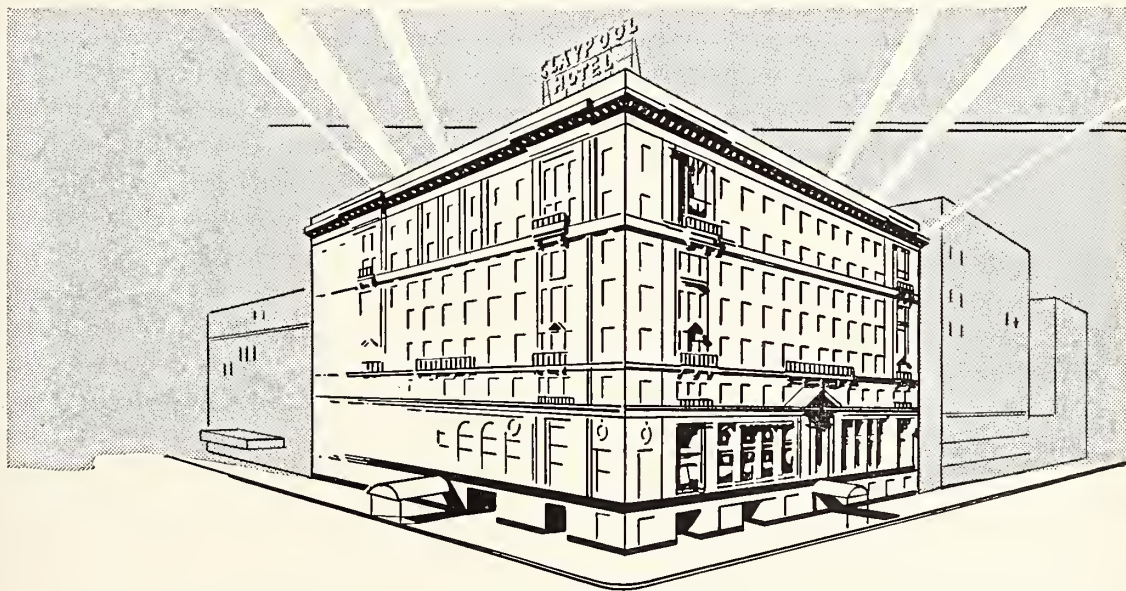
"Your Reference Committee on Amendments to the Constitution and Bylaws begs to report as follows:

"That Article IX of the Constitution be amended by adding an additional section to be numbered Section 9 to read:

"In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor.

In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the executive secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call."

"And that the Article be further amended by renumbering present Section 9 to make it read Section 10."



*In Indianapolis, Indiana—choose...*

# HOTEL CLAYPOOL

Completely Air-Conditioned . . . Radio and Television in Guest Rooms

**A n A F F I L I A T E D N A T I O N A L H O T E L**

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# Technical Exhibits

October 25, 26 and 27

8:30 a.m.—5:30 p.m.—Monday and Tuesday

8:30 a.m.—3:30 p.m.—Wednesday

## Booth COMPANY and PRODUCTS

### 105 Abbott Laboratories, North Chicago, Illinois

The Abbott exhibit will feature NEMBUTAL®, a short-acting barbiturate with a wide range of uses. NEMBUTAL can produce any desired degree of cerebral depression with only about one-half the dosage required with many other barbiturates. Among the NEMBUTAL products to be displayed will be capsules, tablets, elixirs, suppositories, solutions and sterile powder for solutions.

### 67-68 Akron Surgical House, Inc., Indianapolis

Clarence Lippott—Ed Hallyburton

Members of the Indiana State Medical Association and their guests are invited to visit our booth. Our representatives, Clarence Lippott and Ed Hallyburton, will be pleased to discuss any products in which you may be interested.

### 42 A. S. Aloe Company, St. Louis, Missouri

Herb Detrick, Kel Howton, Jim Roche

Visit Booth No. 42 where the Aloe representatives will show you a cross-section of the complete line of physician's equipment and supplies carried by the A. S. Aloe Company. Highlighted will be the new Steeline Pediatric Table and the Aloesonic for ultra-sound therapy.

### 49 American Ferment Co., Inc., New York 18, N. Y.

F. W. Dulle, E. J. Kretz

Will feature increased *in vivo* digestion and utilization of dietary proteins through use of the proteolytic enzyme "Caroid". Caroid and Bile Salts Tablets and Alcaroid Antacid, both containing "Caroid"; and Supligol, a whole bile-ketocholanic acid compound useful in the management of early biliary dysfunction will also be shown.

### 57-58 American Hospital Supply Corporation, Evanston, Illinois

T. W. Chawck, John Arns, Howard Henderson

Scientific Products Division, American Hospital Supply Corporation, will have on display the complete line of Baxter intravenous solutions and accessory sets, including the new electrolyte solutions as well as Gentran, an effective, proven plasma volume expander for use in the treatment of shock, and the new Plexitron Blood Pump for safe, rapid pressure transfusions with expendable equipment. Also on display will be Hemolets, a sterile, disposable blood lancet; Dade Human Blood Serums, and other new products for clinical laboratory work.

## Booth COMPANY and PRODUCTS

### 63 Ames Company, Inc., Elkhart, Indiana

Robert F. Myers, in charge; Jerry A. Cashen, and D. LeRoy Hussey, Division Sales Manager CLINITEST, for urine-sugar analysis, is standardized. This assures uniformly reliable results whenever and wherever a test is performed—office, ward clinic, or patient's home. Standardization not only curtails error, but saves personnel's time by elimination of preparing and mixing of reagents.

ACETEST for acetonuria, BUMINTEST for albuminuria, HEMATEST for occult blood, and ICTOTEST for bilirubin will also be on display.

### 35 Ayerst Laboratories, New York 16, New York

G. W. Forry, District Manager; J. R. Minton, Samuel A. Muir, Jr.

We take great pleasure in extending a cordial invitation to all physicians attending the Annual Convention of the Indiana State Medical Association to visit Booth No. 35 where literature and information on "Trilene," "Premarin," and other Ayerst specialties will be available. Representatives will also be pleased to discuss many new Ayerst products with you such as "Kerodex," "Mysoline," and "Clusintrin."

### 75 Baby Development Clinic, Chicago 5, Illinois

Mrs. Hermien Nusbaum, Mrs. Eunice Cline, Arthur Syroth

MATERNITY COUNSELLING SERVICE offers demonstration material to aid in teaching expectant mothers; care and support of breast; support of abdomen and relief of back strain; care of the skin. Preparation for infant and child care aids on bathing; feeding; sleeping; toileting. Material also available for Well Baby Conferences.

### 73-74 Baker Brothers, Inc., Indianapolis

Frank M. Jones, Mrs. Frank M. Jones, Frank C. Jones

Once again Baker Brothers will be looking forward to seeing our friends.

We invite your inspection of the latest equipment in Hospital Beds, Wheel Chairs, Walkers, Crutches, Hydraulic Lifts, etc.

Come in and meet the people who are dedicated to "Serving the Sick and the Handicapped."

**Booth COMPANY and PRODUCTS****64 The Baker Laboratories, Inc., Cleveland 3, Ohio**

R. W. McNamara, R. W. Hendricks

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

**39 Bard-Parker Company, Inc., Danbury, Connecticut**

Charles W. Petzold

RACK-PACK . . . the new method of packaging B-P RIB-BACK Surgical Blades. Now in a matter of seconds, blades are ready for sterilization. Saves time and labor in the O.R.; protects against costly, accidental damage to sharp edges. Also knife handles, B-P Germicide, Chlorophenyl, sterilizing containers, transfer forceps, pipettes, and The Reese Dermatome.

**80 Beechnut Packing Company, Canajoharie, New York****108 Brooks Appliance Company, Chicago 2, Illinois**

W. C. Ayer

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer Bandage plus the Dalzoflex Elastic Adhesive which are used in treating leg ulcers and phlebitis.

Elastic Stockings, the Nulast Elastic Crepe Bandages, and Surgical Instruments will also be displayed.

**48 Brown & Williamson Tobacco Corporation, Louisville 1, Kentucky**

VICEROY (Filter Tip) Cigarettes

J. W. Shuler, S. S. Burnett, Howard Means, Jr., J. G. Crume

The new King-Size VICEROY Filter Tip Cigarette gives the smoker DOUBLE THE FILTERING ACTION to double his smoking pleasure.

There are 20,000 tiny filter traps in VICEROY'S new filter of pure, non-mineral ESTRON. It filters the smoke, yet draws freely and gives the smoker the full, rich taste of choice tobaccos.

An explanation of the unique advantages of VICEROY will greatly interest members and guests who visit the VICEROY exhibit.

**Booth COMPANY and PRODUCTS****117 Brown & Williamson Tobacco Corporation, Louisville, Kentucky**

KOOL (Mildly Mentholated) Cigarettes

J. W. Shuler, S. S. Burnett, Howard Means, Jr., J. G. Crume

Many members of the medical profession are showing unusual interest in KOOL (mildly mentholated) cigarettes for which there is a wide and growing acceptance among smokers troubled with throat irritations or respiratory disorders.

Members who visit the KOOL exhibit will receive an attractive souvenir and a folder of interesting facts relating to the application of cooling menthol to tobacco.

**69 Burroughs Wellcome & Co. (U. S. A.) Inc., Tuckahoe 7, New York**

J. W. Bolton, R. O. Robinson, R. E. Tower

'NEOSPORIN'® brand Polymyxin B—Bacitracin-Neomycin

**ANTIBIOTIC OINTMENT**

- Wherever there is topical bacterial infection.

'MAREZINE'® Hydrochloride brand Cyclizine Hydrochloride Controls:

- Nausea and vomiting of pregnancy.
- Motion sickness.
- Vertigo.

Syrup of 'ANTEPAR'® Citrate brand Piperazine Citrate

- To eradicate pinworms and roundworms.
- Pleasant to take.
- Quickly effective.

**79 The Central Pharmacal Company, Seymour, Indiana**

W. W. Torrens

Our exhibit will feature three original Central products namely, TRISULFAZINE, CENASERT and NEOCYTEN.

The TRISULFAZINE products are offered in three dosage forms: Palatabs, Syrup and Tablets. These products represent the original triple-sulfa specialities, and were the first ones to be accepted by the council.

CENASERT Tablets and Powder are used in the treatment of trichomonas vaginalis, vaginitis, monilial and mixed nonspecific infections of the vaginal tract.

NEOCYTEN is a product which effectively combats both pain and spasm in rheumatoid arthritis, bursitis, fibrositis, and other neuromuscular dysfunctions.

**95 Chicago Pharmacal Company, Chicago, Illinois**

Chicago Pharmacal features the following Chimedic products of its quality line: URISED, nationally-known and clinically proven tablet for cystitis, which performs both a thorough antiseptis and sedation; TOLYPHY, the improved spasmolysis formula, in tablet and liquid form; THIONICAVIN, balanced "B" injectable, which requires no refrigeration for stability.



**Booth COMPANY and PRODUCTS****46 Ciba Pharmaceutical Products, Summit, New Jersey**

Walter H. Cory, R. G. Fortune, M. Kitterman

**SERPASIL**

The CIBA exhibit will feature SERPASIL, a pure crystalline alkaloid of Rauwolfia possessing the essential antihypertensive actions of the whole root. SERPASIL offers mild, gradual, sustained lowering of blood pressure with a slowing of the heart rate; a tranquilizing effect beneficial in most cases of hypertension; and unvarying potency.

**44-45 The Coca-Cola Company, Atlanta 1, Georgia**

Glen Barnes, Ford Carmin, George Kramer, Fred Dickson

Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Indianapolis and The Coca-Cola Company.

**82-83 Curtis & French, Inc., Indianapolis 2, Indiana**

The following sales personnel of Curtis & French, Inc., will be in our booth to offer the profession the latest information on Medical and Scientific equipment: Jack Curtis, Mac McCain, Bob Ettinger, Jim Traub, Al Dowd and Joe Carey.

All name brands such as Allison, Pelton, Sklar, Stille, Liebel-Flarsheim, Bovies, Castle, American Metal, Champagne, and Ritter equipment will be on display.

**98 Dairy Council**

**South Bend—Indianapolis  
Evansville—Fort Wayne  
Units of National Dairy Council**

You are cordially invited to visit our booth for a cold, refreshing drink of milk. Dairy Council health education materials will be on display. These materials are free of charge in the localities which have affiliated units.

**138 The Dick X-Ray Company, Indianapolis, and St. Louis, Missouri**

L. E. Summers, Roy Hinman, Art Kistner, Ed Meek, Sam Cornan

The Dick X-Ray Company will have on display —100 M.A. Profexray—complete with Automatic Control, Tilt Table and new type Radiographic X-ray tube.

Also, Cambridge electrocardiograph Direct Writer and Liebel-Flarsheim Diathermy.

**Booth COMPANY and PRODUCTS****118 Doho Chemical Corporation, New York, New York**

Karl Coleman

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in otitis media and removal of cerumen; NEW OTOSMOSAN, non-toxic fungicide and bactericide for suppurative and aural dermatomycotic ears; and RHINALGAN, a nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged. Mallon Chemical Corporation, Subsidiary of the Doho Chemical Corporation is also featuring RECTALGAN, the liquid topical anesthesia, also for relief of pain and discomfort in hemorrhoids, pruritus and perineal suturing.

**22 Eberbach & Son Co., P. O. Box 63, Ann Arbor, Michigan**

Eberbach & Son Company, distributors of laboratory equipment and supplies, will exhibit the new Coleman Flame Photometer. It measures Sodium, Potassium and Calcium directly. Easily operated by inexperienced hands, this fine new instrument burns city illuminating gas and oxygen. This amazing new Flame Photometer has a new self aligning atomizer which is easy to keep clean. The very small flame will not heat up the laboratory, and only small quantities of sample are needed.

Other items on display will include the well known Eberbach Clinical Shakers and Rotators.

**106 EDISON VOICEWRITER Dictating Instruments Van Ausdall & Farrar, Indianapolis**

C. J. Clarke, Joe Smith, C. W. VonGrimmenstein, Bob Hall, C. F. Farrar

For MEDICAL RECORD keeping the NEW EDISON "V. P." has proven to be the most versatile. It's portable—your secretary can use the same instrument to transcribe from (reduces cost)—it uses the Edison Diamond Discs (mailable, fileable and inexpensive) as used by many Indiana hospitals for record keeping. For the clinics and hospitals not equipped, ask about Edison Televoice—the remote control dictation system designed for clinical recording.

All instruments can be equipped for conference and telephone recording.

Ask for a trial in your own office—when you visit Booth 106.

**77 Paul B. Elder Company, Bryan, Ohio**

Neil T. Levenson, Allan H. Innis, Paul Klinkenberg

We are very pleased to invite members and guests of the Indiana State Medical Association to visit our booth. We will feature 2 new drugs —BENOQUIN® Ointment and METORBIC Capsules.

BENOQUIN is a unique drug for treatment of hyperpigmentation due to melanin which is frequently encountered in general practice. METORBIC Capsules are specifically designed for accelerating wound healing.

**Booth COMPANY and PRODUCTS****76 Encyclopedia Americana, Grand Rapids, Mich.**

Armin Eastman, Lorraine Eastman

We will be pleased to have you inspect our 1954 *Edition of the Encyclopedia Americana*—worldwide in scope yet American in spirit, and also the *Heritage Edition of the Book of Knowledge for Children, An American Tradition*—both keyed to the exact principles of our school system and both included in one exhibit offer.

**100 C. B. Fleet Co., Incorporated, Lynchburg, Virginia**

William J. Foley, Jr.

During the past fifty years PHOSPHO-SODA (FLEET) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT—an enema solution of Phospho-Soda (Fleet)—is a worthy companion product. The single use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

**37 Freeman Manufacturing Company, Sturgis, Michigan**

Makers of Orthopedic Supports

A. J. McNamara

For more than sixty years Freeman has been engaged in making surgical supports and elastic hose. During that time we have worked closely with members of the medical profession. Their assistance has proved invaluable in enabling us to maintain the highest standards of quality and design.

We particularly invite your inspection of our complete line of orthopedic supports being exhibited at the show.

**135 Freeman X-Ray Co., Chicago 30, Illinois**

Charles Freeman, Earl Hamren, Joseph Monteleone

Freeman X-Ray Co., will display something entirely new in both low and high capacities X-Ray Units. The NEW MATTER low cost 100 MA Unit will be demonstrated. Experienced X-Ray men will be in attendance.

**120 Geigy Pharmaceuticals, New York 13, N. Y.**

Louis G. Kohlberg, Charles M. Hoskins

The Geigy Exhibit features Council-accepted BUTAZOLIDIN® (brand of phenylbutazone), an orally effective compound which has achieved great clinical success in the treatment of rheumatoid disorders. Also on display will be Council-accepted TROMEXAN®, an oral anticoagulant of rapid action and little cumulation: EURAX® Cream and EURAX® Lotion, a long-acting, non-sensitizing, antipruritic

**Booth COMPANY and PRODUCTS**

and scabicide, PANPARNIT®, indicated for symptomatic relief of Parkinson's Disease and STEROSAN® Cream and STEROSAN® Ointment, a bacteriostatic and fungistatic agent for the local treatment of pyogenic and mycotic skin disorders.

**59 General Electric Company, Indianapolis 4**

W. Christenson, R. C. Johnston, Orval Paul, J. Haskell Standard, H. J. Wallace, E. W. Horner

The General Electric Company, X-Ray Department, Milwaukee, Wisconsin with direct factory offices at 306 Chamber of Commerce Building, Indianapolis will feature a new model Direct Writing Electrocardiograph in booth 59 at the State meeting starting October 25.

The personnel listed above will be in attendance to welcome visitors.

**86 Gerber Products Company, Fremont, Michigan**

Russell Callahan; Donald Rasico

WHEN MILK IS CONTRAINDICATED as the basic food for infants, Gerber's "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods. You are also invited to review new editions of Gerber's baby care and adult special diet booklets. Each is designed especially for distribution by physicians. Each provides non-controversial information in simple, easy-to-understand language. The service is complimentary.

**61 J. E. Hanger, Inc., Indianapolis**

M. G. Manwaring, Jack Talbert, Frank Shirrell

J. E. Hanger Incorporated, America's oldest and largest manufacturer of prostheses will again present an outstanding display featuring the latest developments in the prosthetic field both for lower and upper extremity amputees. Experienced personnel will be available to discuss with the profession the needs of their patients and demonstrate the types best suited to the individual patient's prosthetic need.

**32 H. J. Heinz Company, Pittsburgh 30, Pa.**

H. E. Johnson, F. B. Heard

The H. J. Heinz Company is the first to introduce strained meats in glass jars. They are the newest addition to the Heinz line of baby foods. Physicians and mothers alike are most happy to have strained meats in glass packages. Beef, Liver, Lamb, Beef Heart, Pork and Liver and Bacon are now available, with other meats to be added later.

These all-meat varieties plus the other strained and junior foods give the mother a complete line—over fifty varieties—of Heinz baby foods in glass jars.

Now, for your use, Doctor, there are: Nutritional Data, Variety and Ingredient Listing Pads and for Mother's use, Strained and Junior Foods literature.

**Booth COMPANY and PRODUCTS****114 The J. C. Hirschman Co., Inc., Indianapolis 7, Indiana**

J. Clifton Hirschman, Lester W. Martin, Joe Elzey, William S. Taylor.

We proudly display the Serta PERFECT SLEEPER Tuftless Innerspring Mattress.

It's healthful; you sleep with firm head-to-toe support. It's scientifically correct because SERTA'S patented UNIMATIC INNERSPRING CONSTRUCTION, is built to specifications approved by doctors, and proved by X-rays. They prove how the PERFECT SLEEPER'S overall support permits greater relaxation, more healthful sleep—and assures precious posture protection.

You sleep **ON** it—not **IN** it!!!

Also on display is the SERTAPEDIC Tuftless Innerspring Mattress. Hirschman believes that if your back aches . . . see your doctor. If he tells you to change your mattress . . . get the extra-firm, smooth-top SERTAPEDIC! 400 doctors helped Serta design this scientifically-correct mattress. This mattress is designed with the same high specifications as the SERTA PERFECT SLEEPER Mattress, plus, an extra firm Uni-matic Coil Spring Unit, high grade cotton felt, and expensive 8 oz. woven tick.

For that vital Posture-Protection that helps you look and feel top-o-the-morning all day long . . . ask for the only SERTAPEDIC Mattress!!

**96 Hoffman-LaRoche Inc., Nutley 10, New Jersey**

You will find three products of special interest to the surgeon featured in the Roche display: the synthetic narcotic, LEVO-DROMORAN for relief of severe pain; the soluble, sulfonamide GANTRISIN for antibacterial action and the new chemical compound ILIDAR which is particularly valuable in vasospasm and related peripheral vascular disorders.

**88 Holland-Rantos Company, Inc., New York, New York**

Harry H. Beeman, Indianapolis; Elton L. Tosch, Hobart; Ernest W. Kowal, McHenry, Ill.

Physicians interested in Medical Contraception are cordially invited to discuss with H-R convention representatives the latest information on clinical and laboratory data concerning the efficacy of KOROMEX products. Also on display will be seen NYLMERATE JELLY—reportedly one of the 200 most widely prescribed pharmaceutical preparations—and NYLMERATE ANTISEPTIC SOLUTION CONCENTRATE. To the three-fold *trichomonocidal*, *fungicidal* and *bactericidal* action of NYLMERATE preparations may be attributed their excellent clinical value—not only in vaginal trichomoniasis and moniliasis, but also in mixed infections and in presence of secondary bacterial invaders.

**Booth COMPANY and PRODUCTS****119 Indiana Bell Telephone Company**

The Telephone Booth will feature the economy and value of Long Distance Calls and the value of adequate listings in the classified section of the Telephone Directory. The two items will be covered by poster displays only.

The new style answering and recording device to be connected to the telephone for taking calls during the absence of the customer will be featured. This is very desirable for small offices not employing a secretary or nurse and for the doctor who is interested in being able to receive calls on a 24 hour basis. An announcement may be recorded in the doctor's voice and provisions are made to record a total of 10 minutes and the individual message may be up to 30 seconds.

**24 Indiana Brace Shop**

T. M. Davidson, M. E. Miller, Registered Orthotists.

The exhibit will include: Camp Anatomical supports, plastic cervical braces, leather collars, Jewett Hyperextension braces, Taylor back braces, cerebral palsy braces, both aluminum and steel, various types of steel and aluminum parts for leg braces. Also on display will be Burnell hand splints, Frejka splints, Denis Browne adjustable splints, Lofstrand crutches, arch supports and shoe corrections of all types.

**93 Indianapolis Artificial Limb Corporation, Indianapolis 4, Indiana**

S. E. Hedges, Joseph Garoffolo, Ray V. Bishop

It is with a great deal of pleasure that we present you—our physician friends—with our exhibit booth No. 93. We are now celebrating our "THIRD ANNIVERSARY" in the Prosthetic Field. You will find on exhibit the latest developments in prosthetic appliances, whether it be upper or lower extremities. Among our lower extremity appliances you will find, The C. H. Bennington "MODERN LIMB", with the Variable Knee Control, for thigh wearers. This, we believe to be the greatest improvement today in lower extremity prostheses.

You will also see a full line of appliances for upper extremities. These you will find both functional and cosmetic in appearance.

Please accept our invitation to visit us and let us demonstrate these limbs. Should you have in mind some patient that has recently suffered the loss of a limb, feel free to discuss your case with us.

**26 Irwin, Neisler & Company, Decatur, Illinois**

Mr. DeLong, Mr. Knudsen, Mr. Hart

We of Irwin, Neisler and Company believe that new drugs should not only pass the most rigid experimental and clinical tests, but should also prove practical for the day-to-day practice of medicine.

We would like to tell you about Cryptenamine, the new and safe hypotensive drug. This drug is dramatic, particularly in managing acute hypertensive states. Ask us about it at Booth No. 26.



**Booth COMPANY and PRODUCTS****Booth COMPANY and PRODUCTS****5-6 Keleket X-Ray Corporation, Covington, Kentucky**

Victor S. Johnson, Indianapolis, manager; B. J. Anderson, H. Thurresson; F. Temmen; Miss G. Hostetler

KELEKET—the oldest name in X-Ray—is introducing the 100 MA at 100 KV Full Wave Rectified KELESCOPE. Here is an economy priced diagnostic X-ray unit providing simple automatic operation, full size and complete facilities for perfect radiography and fluoroscopy right in the doctor's office. Designed for minimum space requirements, this full size complete unit may be installed conveniently in a room 8' x 10' and up.

You are invited to have a demonstration at the Keleket exhibit and a trained staff will be on hand daily to greet you and answer your inquiries during the convention.

DOCE, a broad spectrum oral hematinic for treatment of macrocytic and microcytic anemias, as well as a full line of precision pharmaceuticals approved by the Council on Pharmacy and Chemistry of the American Medical Association.

**60 J. B. Lippincott Company, Philadelphia 5, Pa.**

Robert G. Lawson

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

**29 P. Lorillard Company, New York 18, N. Y.**

P. Lorillard Company, manufacturers of OLD GOLD and EMBASSY Cigarettes as well as BRIGGS Pipe Mixture and other famous tobacco products will exhibit and demonstrate their new KENT Cigarettes with the exclusive Micronite Filter, which takes out up to 7 times more nicotine and tars than other filter cigarettes.

**87 M & R Laboratories, Columbus 16, Ohio**

John Reed, Joe O'Rourke, Bob Wilson

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

**25 Maico of Indiana, Indianapolis 4**

G. M. Burrill, John Kenwood

MAICO OF INDIANA,  
MAICO OF FORT WAYNE,  
MAICO OF SOUTH BEND,

distributors of medical acoustical instruments, welcome all physicians and allied professions to Booth No. 12. Maico supplies 90 percent of all hearing test instruments in the world, as well as being foremost in fine hearing aids. Competent and courteous representatives assist in surveys of industrial noise levels and hearing conservation testing programs.

**70 Paul Maney Laboratories, Incorporated, Cedar Rapids, Iowa**

Charles Rogers, Kenneth McCracken, Harry Diman, Elkhart; William Tougan, Vincennes

We will be happy for you to visit our booth and discuss with us the many specialities in our line. Featured will be, four preparations of powdered whole root Rauwolfia Serpentina. Also, our recently Council Accepted preparation, Neothyl-line, will be on display. We do hope that you will take time out to visit our booth.

**1 Kremers-Urban Co., Milwaukee 1, Wisconsin**

Welcome to the K-U exhibit. Featured medications will include SALIMEPH-C and PHYATROMINE-H for relief of pain and spasm in rheumatoid arthritis and related conditions . . . KUSED for sedation without depression . . . KUTAPRESSIN for conditions associated with abnormally dilated arterioles and capillaries.

**139 Lederle Laboratories, Division American Cyanamid Company, New York****104 Eli Lilly and Company, Indianapolis**

G. G. Horton in charge of exhibit; P. A. Holsapple, R. L. McKenna, R. N. Thomas

You are cordially invited to visit the Lilly exhibit located in space No. 104. The display will contain information on recent therapeutic developments and will feature the story of the Lilly Junior Taste Panel. Lilly sales people will be in attendance. They welcome your questions about 'Potycin' (Erythromycin, Lilly) and other Lilly products.

**43 Lincoln Laboratories, Inc., Decatur, Illinois**

N. E. Titus

Lincoln Laboratories will exhibit its pioneer line of Steroid Hormone Emulsions, as well as the new HEXATHRICIN Automatic Aeropak for treatment of burns, ETHAVERINE HYDROCHLORIDE, a non-narcotic spasmolytic and vasodilator, HEXATHRICIN OTIC, for bacterial and fungal infections of the ear, and COBE-

**Booth COMPANY and PRODUCTS****137 The S. E. Massengill Company, Bristol, Tennessee**

M. W. Pully, E. L. Smith, W. J. Barry, J. R. Mills

You are invited to visit the S. E. Massengill Company booth. Adrenosen, the new Massengill systematic hemostat, is featured. Adrenosen is specific in treating those conditions characterized by increased capillary permeability. Our representatives will be glad to discuss with you the latest information and clinical evaluations of this product.

**50 McNamara Medical Equipment Company, Detroit 5, Michigan**

Jack Walker, Paul Mandabach, Gerald McNamara

McNamara Medical Equipment Co. of Detroit, Michigan is servicing the profession with a COMPLETE LINE OF PHYSICAL MEDICINE EQUIPMENT including HYDROCOLLATOR, MOISTAIRES, ILLE HYDROTHERAPY, RESTORATOR, PAUST ELECTRONIC STIMULATOR, ULTRASONIC, ULTRAVIOLET, SHORT WAVE DIATHERMY, MICROTHERM, WHEEL CHAIRS and ANATOMOTOR TABLES, ALL THE NECESSARY APPURTENANCES. We shall be happy to serve you.

**51 McNeil Laboratories, Inc., Philadelphia 32, Pa.**

W. C. Dollens, R. H. Powers

Members of the Indiana State Medical Association are cordially invited to visit our booth No. 51, Mr. W. C. Dollens in charge. Products to be featured are Butisol Sodium, Syndrox Hydrochloride, Clistin Maleate, Butisol-Belladonna, Sustinex, Cinbisal, Algoson, Syntil and Pronatin.

**2 Mead Johnson & Company, Evansville 21, Indiana**

Mead Johnson & Company Booth No. 2 will display the following products: Lactum (powdered and liquid forms), Mead's nutritionally sound formula for infants; Liquid Sobee, a hypoallergenic soya formula (milk free); Natalins and Natalins-T, Mead's maintenance and therapeutic prenatal capsules; Mulcin; Poly-Vi-Sol and Tri-Vi-Sol.

**102 Medco Products Company, Tulsa 12, Oklahoma**

Kenneth L. Huntsman, Fort Wayne

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

**Booth COMPANY and PRODUCTS****7 Medical Plastics Laboratory, Gatesville, Texas**

A. C. Hays, Sales Manager

Plastic human skeletons developed and manufactured by Medical Plastics Laboratory of Gatesville, Texas and publicized in journals and newspapers may be seen in Space No. 7. These are extremely accurate reproductions of human bones with all anatomical markings, true bone texture and color. Immediately available, clean and lower cost are a few of the many advantages plastic bones offer.

**56 The Medical Protective Company, Fort Wayne**

Exclusive application to the field of Professional Liability Insurance endows The Medical Protective Company with a "know-how" in Defense that produces superior protection for the Doctor. This Defense is provided at the Company's cost and is unlimited as to the amount expended. It makes possible an enviable record in which policy holders suffer no involuntary loss from their own pockets in the payment of malpractice damages.

**66 The Wm. S. Merrell Company, Cincinnati 15, Ohio**

H. O. D. Boone, Clyde Johnson, Indianapolis

The Wm. S. Merrell Company presents Bentyl, the safe, effective, yet comfortable antispasmodic that is superior to atropine and belladonna for relief of nervous indigestion.

Bentyl has a musculotropic action like that of papaverine, and a neurotropic action like that of atropine. Because of its unique specificity for the G. I. tract, Bentyl is virtually free of the side effects generally associated with antispasmodics, and offers effective relief without "belladonna backfire."

Literature, including reprints reporting more than 1500 clinical cases treated with Bentyl, is available at the booth.

**94 Miller Surgical Company, Chicago 39, Illinois**  
Wm. E. Mettler

MILLER SURGICAL COMPANY, Chicago, Ill.

(Booth 94) will show the Miller Electro-Scalpel. This unit cuts, desiccates, fulgurates, coagulates and is used for most delicate work up to light major surgery. Accessories such as Snares, Smoke Ejectors, etc. also available. A complete line of Diagnostic Equipment consisting of Illuminated Oscopes, Ophthalmoscopes, Eyespud with Magnet, Transillumination Lamps, Headlights, Vaginal Speculum with Smoke Ejector, and the Gorsch type Operating Scopes, and stainless steel Proctoscopes, all sizes with magnification, Suction Tubes, and Grasping Forceps.

**Booth COMPANY and PRODUCTS****23 Modern Drugs, Inc., Indianapolis 25, Indiana**

K. E. Hoy, Sr., K. E. Hoy, Jr., B. C. Dell

Modern Drugs, Inc. will feature, at the annual meeting of the Indiana State Medical Association, several outstanding products for parenteral administration.

Among these is Calphosan, the superior calcium parenteral solution for lasting effect. Dramatic response is obtained in allergies, dermatoses, neuromuscular spasmophilic manifestations, and in all cases where low serum calcium is even remotely suspected. A 10 cc. dose of Calphosan can be injected, even subcutaneously or intramuscularly, without pain and free of side effects. Corticotropin (ACTH) in a superior gel which will give full therapeutic activity for 24 hours or longer; a free flowing aqueous suspension of Penicillin, and many other products.

**3 Bill Moss, Inc., Bloomington, Indiana**

Bill Moss, Mrs. Moss, Ted Williams

Bill Moss, Inc., Bloomington, catering to the dispensing physician, will exhibit medications for use by the profession. The exhibit will feature PAVEROID the powerful new antispasmodic which has been written up extensively. For use in coronary, angina and similar cases the product is non-toxic, non-narcotic and non-habit forming.

**78 Mutual Medical Insurance, Inc. (The Blue Shield Plan), Indianapolis**

R. S. Saylor, L. E. Converse

Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth No. 78.

Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public, and showing the growth of the Plan in membership during the past five years.

Dr. Walter U. Kennedy, New Castle, is president of the Blue Shield Plan; Dr. W. Harry Howard, Hammond, is vice-president; Dr. Walter L. Portteus, Franklin, is secretary; and Mr. Elmer W. Stout, Indianapolis, treasurer.

Administration of The Blue Shield Plan is under the direction of R. S. Saylor, Executive Vice-President, 500 Terminal Building, Indianapolis.

**99 Ortho Pharmaceutical Corporation, Raritan, New Jersey**

ORTHO cordially invites you to booth 99 where the well known line of obstetrical and gynecological pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Ortho representatives will be on hand to offer pertinent information on their products.

**Booth COMPANY and PRODUCTS****30-31 Original CONTOUR-chair LOUNGE, Indianapolis 2**

Mrs. Elizabeth K. Bonheim, Myron W. Bonheim, Miss Norma Robertson

DOCTOR . . . be sure to see the ORIGINAL CONTOUR-chair LOUNGE on display in Booths 30 and 31.

The chair that secures cooperation of patients in accepting prolonged rest regimen; Patients not deprived of social activities and contacts, morale improved thereby; Patients' gratitude to doctor for suggesting CONTOUR-chair LOUNGE replaces customary resentment over imposed inactivity.

Right here and now, we want to take the opportunity to thank the many physicians who have recommended Original CONTOUR-chair LOUNGES to their many patients.

We regard your recommendations highly, and will bend all our energy towards meriting your continued confidence in the Original CONTOUR-chair LOUNGE.

During this Annual Convention, October 25-26-27, 1954—10% Discount to all members of the Medical Profession.

AS GOOD FOR YOU, DOCTOR,  
AS FOR YOUR PATIENT!

**4 Parke, Davis & Company, Detroit 32, Michigan**

M. O. Hollingsworth, W. E. Thum

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxyeel, Milontin, Amphetase, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

**81 The Pelton & Crane Company, Detroit 2, Michigan**

C. K. Vaughan

High-speed autoclave sterilization can now be accomplished in three sizes of autoclaves that are completely self-contained. No water or waste connections are needed. Just plug them in and steam under pressure is available all day long for immediate sterilization.

Only Pelton makes the autoclave that generates and then stores steam in a reserve chamber. The small FL-2 with a 6 x 12 chamber is ideal in the private office. The larger HP-2 with an 8 x 16 chamber and the LV-2 with a 12 x 22 chamber are both ideal for the small clinic or hospital and as standby equipment in large hospitals. See them demonstrated in Booth 81.

**53 Pet Milk Company, St. Louis, Missouri**

A. E. Bower, P. W. Raley

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets. A miniature can of "Pet" Evaporated Milk will be given to all visitors.



**Booth COMPANY and PRODUCTS****136 Pfizer Laboratories, Brooklyn 6, New York**

Milton Stamper, in charge; Wayne Snyder, Max Beeson, George F. Penny

You are cordially invited to visit the Pfizer booth. TERRAMYCIN INTRAMUSCULAR holds the spot light this year with a star-studded cast which includes Cortril (brand of hydrocortisone) in several convenient dosage forms, and the complete line of Pfizer-Syntex steroid hormones.

Another newcomer to the Pfizer display is Bonamine, the first compound effective against motion-sickness in a single daily dose.

111-

**112 Picker X-Ray Corporation, White Plains, New York****109-110 Pitman-Moore Company, Division of Allied Laboratories, Inc., Indianapolis 6, Indiana**

Lester E. Davis, Central Regional manager, William McCrory, William Creek

The Pitman-Moore exhibit will feature Veralba, a brand of protoveratrine A and B, for the effective treatment of hypertension; Veralba-R, a new combination of Veralba and reserpine, also for the management of hypertension; Novahistine Liquid and Tablets, for the relief of nasal congestion through oral administration; and Neo-Polycin, a highly effective topical ointment containing polymyxin, bacitracin and neomycin in the distinctive Fuzene base.

**92 Rex Typewriter Exchange, Indianapolis 4**

Curt Benner, Jan Eden

Be sure to visit the Rex Typewriter Company booth. We will have on display all the latest models of Webster Chicago Wire Recorders, tape recorders, and 3-speed record players. See the new Hi-Fidelity "Musical" record player which is available in either mahogany or blond finish. Also see the Web-Cor Tape recorder Model 2010 that records up to two hours, and has fast forward and fast reverse speeds for your convenience. The new Model 228 wire recorder will fit all your dictating and transcribing needs at a very low cost.

Also on display will be adding machines and typewriters suitable for physicians' offices. Be sure to see the "swift" adding machine which weighs only 6½ pounds, and takes up a nominal amount of space.

**36 R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina**

C. F. Cavendish, J. M. Herbert

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL; CAVALIER King Size; or WINSTON, the distinctive new king size, cork tip, filter cigarette.

**Booth COMPANY and PRODUCTS****84 A. H. Robins Company, Inc., Richmond, Virginia**

D. W. Otoupal, L. E. Heinmiller

The A. H. Robins Company exhibit features ROBALATE, N.N.R., antacid-demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 Gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability.

**113 J. B. Roerig & Co., Chicago 11, Illinois**

Vic Market, Bill Hastings

Attending physicians and their friends are cordially invited to visit the J. B. Roerig and Company exhibit in Booth 113, where experienced professional representatives will have some clinical information on Tetracycline—the newest broad spectrum antibiotic. They are prepared and will be glad to answer questions regarding its use in the various dosage forms and its efficacy in many infections. Samples will be available for clinical trial.

Information on and samples of Roerig's well established nutritional products will also be available to visiting physicians on request. Viterra, Viterra Therapeutic, Amplus, Heptuna Plus, Obtron and Obtron Hematinic, including A S F, Roerig's newest product—an anti stress formula which meets the recommendations of the National Research Council.—J. B. Roerig and Company—Booth 113.

**62 Sandoz Pharmaceuticals, Division of Sandoz Chemical Works, Hanover, New Jersey**

Robert N. Pitts

Sandoz Pharmaceuticals extends a cordial invitation to visit our display at the Indiana State Medical Association Convention—Booth No. 62. PLEXONAL: Sandoz introduces a new sedative-hypnotic—Plexonal. This exhibit demonstrates that Plexonal is not just another sedative, but is one developed on a new pharmacologic approach. The action of subthreshold doses of classic sedative agents are potentiated and enhanced by autonomic and central acting drugs.

CAFERGOT: The first effective oral therapy for migraine and related vascular headaches—clinically proven in thousands of reported cases since 1949.

FIORINAL: A new approach to therapy of tension headache and other head pain due to sinusitis and myalgia.

HYDERGINE: A new approach and new product for hypertension and peripheral vascular diseases.

Our representative in attendance, Robert N. Pitts, will gladly answer questions about these and other Sandoz products.

**Booth COMPANY and PRODUCTS****140-141 Sanka Coffee, New York, New York**

Miss Carol Brower, Maxwell House Division of General Foods.

It is a pleasure for General Foods to feature Instant Sanka . . . 100% Coffee, with 97% of the caffeine removed . . . at the annual convention of the Indiana State Medical Association. Won't you stop by for your morning cup? And come back for "seconds" between meetings. We shall be happy to serve you and to have you register. Our booklet, What Every Coffee Lover Should Know About Caffein, is available in any quantity you can use.

**85 W. B. Saunders Company, Philadelphia**

Gerald D. Miller

Among some of the newest titles of clinical interest on display at the Saunders booth will be Campbell: Urology; Flint: Emergency Treatment; Hill: Fluid Balance; A.M.A.: Anesthesia; Nelson: Textbook of Pediatrics. Our complete line will be displayed, including such standards as Dorland: Dictionary; Cecil-Loeb: Textbook of Medicine; Current Therapy 1954; and our three Clinics—Medical, Surgical, and Pediatric Clinics of North America.

**91 Schering Corporation, Bloomfield, New Jersey**

Edwin Leinhos, in charge; Robert Le Compte, Maurice Hoban

Members of the Indiana State Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

**8 G. D. Searle & Co., Chicago, Illinois**

Robert W. Schultz, George A. Yotter

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestiril, the new synthetic estrogen with extremely low incidence of side reactions; Banthline, and Pro-Banthline, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

**90 Sharp & Dohme, Division of Merck & Co., Inc., Philadelphia**

P. I. Schiager, in charge; P. M. Rinker, M. B. Lewallen, R. C. Peterman

The many indications for 'Hydrocortone' or 'Cortone' highlights the therapeutic importance of these hormones in everyday practice. A new anesthetic agent 'Cyclaine' Hydrochloride with qualities suitable for such forms of regional anesthesia as infiltration, nerve block, spinal, caudal and topical is of interest. Research data relative to more effective therapy when penicillin is used in conjunction with 'Menemid' completes the exhibit. Expertly trained personnel solicit discussions on these observations.

**Booth COMPANY and PRODUCTS****27-28 SERVEL Inc., Evansville 20, Indiana**

We invite you to see these Servel products:

*Electric Wonderbar*—Portable, silent refrigerator for drugs, biologicals, vaccines, and other medicinal perishables. Ideal for pharmacists, doctors, clinics, hospitals, nurseries.

*Automatic Ice-Maker Refrigerator*—Provides a constant supply of ice cubes automatically, as well as refrigerated storage space. Ice cubes are stored in a basket, loose and ready for use. As they are taken out, the Ice-Maker replaces them automatically. Serves hospital floors, clinics and doctors' offices with a convenient low-cost ice supply. Operates on gas or electricity.

*Electric Room Air Conditioner*—Gives hospital rooms, clinics, doctors' offices, and nurseries a healthfully cool atmosphere in summer. Exceptionally quiet in operation. Filters out dusts and pollen.

**115 Seven-Up Bottling Company, Inc., Indianapolis****89 Smith, Kline & French Laboratories, Philadelphia**

F. J. Forbregd, R. B. French

The S.K.F. booth will feature the latest clinical information about the remarkable new drug—THORAZINE\*—and its many and varied uses. These uses include potent anti-emetic action, potentiation of other drugs, and its unique and dramatic applications in the field of mental and emotional problems.

\* 'THORAZINE'—Trademark, S.K.F.

**41 Spencer Supports, Indianapolis**

Madge<sup>e</sup> L. Robbins; Paul Munger, Medical Director, Spencer, Inc., New Haven, Connecticut; Mary Lou Padget, Mona Nevitt

You are cordially invited to visit the Spencer Supports Booth No. 41 and see the display of abdominal, back, and breast supports which are designed for each individual patient.

The booth attendants will be glad to show you these supports and also tell you about the immediate Emergency Service now available for your patients.

**33 E. R. Squibb & Sons, Division of Olin Mathieson Chemical Corporation, New York 22, New York**

W. D. Sears, in charge; T. L. Howard, H. J. Fry, J. R. Cook

New Squibb Products, and new brochures of useful interest to you on products already introduced, will be featured at Booth No. 33.

As in former years, your Squibb Representative again cordially invites you to visit the Squibb Booth.

**Booth COMPANY and PRODUCTS****116 The Stuart Company, Chicago, Illinois**

Ward McCarty, Ward Jackson

Trained representatives will be glad to discuss Stuart products of interest to members. We are featuring a number of new items that have gained a great deal of attention throughout the country, as well as a number of well known specialties that are familiar to the physician.

**The Studebaker Corporation, South Bend**

The Studebaker automobile which will be given to some member of the Indiana State Medical Association will be on display in the lobby near the entrance to the Exhibit Hall.

**121 Testagar & Co., Inc., Detroit 26, Michigan**

The professional service representatives of Testagar & Co., Inc. will welcome all physicians to discuss the newest skeletal muscle relaxant, MYOMEPHETANE. Other new product developments will be on display. Samples and literature will be available.

**40 S. J. Tutag & Company, Detroit 34, Michigan**

Edward Tutag, Max Hull, Jack Marx

Featured in the S. J. Tutag and Company display, Booth 40, will be Buffonamide and Vagimine Inserts.

Tutag is proud to present Buffonamide the Council Accepted triple sulfa that is buffered. The use of sodium citrate as buffering agent with the acetdiamer-sulfonamides makes Buffonamide ideal; this formula is less toxic, well-tolerated, readily absorbed, with increased crystalluria protection. The pleasant cherry flavoring of this suspension makes Buffonamide the drug of choice for all ages.

Another featured item will be Vagimine Inserts—the new 7-way attack on vaginitis. A dainty insert for use in home or office, avoiding messy powders and liquids. Both germicidal and fungicidal attack is used in this outstanding formula.

**101 U. S. Standard Products Co., Woodworth, Wis.**

Welcome to the U. S. Standard Products booth. Our professional representatives will welcome the opportunity to acquaint you with new medications being added to our expanding line.

**Booth COMPANY and PRODUCTS****65 U. S. Vitamin Corporation, New York 17, New York**

Exhibit features VI-AQUAMIN THERAPEUTIC . . . for the first time *aqueous* therapeutic vitamin formula with minerals in a *single capsule* to hasten recovery in medical, surgical and convalescent patients.

Professional samples and literature on VI-AQUAMIN THERAPEUTIC and other of our nutritional specialties will be distributed at the booth.

**107 The Upjohn Company, Kalamazoo, Michigan**

The Upjohn exhibit will feature CORTEF, brand of hydrocortisone. Reports from clinicians and practitioners reveal dramatic results in the use of CORTEF. CORTEF is available in tablet, I.V., or ointment form for oral, intravenous, or topical use. Upjohn representatives will welcome the opportunity to furnish additional information to the profession.

**72 Varick Pharmaceutical Company, New York 13, N.Y.**

A. W. Jones

E. FOUGERA & COMPANY, Inc. and Division, VARICK PHARMACAL COMPANY, cordially invite physicians to discuss with Professional Service Representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

**71 Warner-Chilcott Laboratories, Division of Warner-Hudnut, Inc., New York 11, New York**

Two important cardiovascular agents will be featured at the Warner-Chilcott booth: Methium—to lower blood pressure and relieve hypertensive symptoms and Peritrate—to prevent attacks in angina pectoris.

A *new* drug, Parsidol—for the efficient management of Parkinson's disease will also be exhibited. Representatives and research personnel will welcome an opportunity to discuss these drugs with you.

**97 The Warren-Teed Products Company, Columbus 8, Ohio**

H. H. Lammey, R. L. Sayre, W. W. Haydock

The Warren-Teed Products Company cordially invites all members of the Indiana State Medical Association and their guests to visit our new exhibit at booth No. 97. This exhibit will feature our new product, Glu-Sal Tablets, a combination of glucuronolactone and salicylamide, indicated for the relief of pain and corrective therapy of rheumatic conditions, arthritis, gout, sciatica, neuritis and neuralgia, by reversal of degenerative changes without side effects. Other products of interest to the medical profession will also be displayed.

Courteous representatives will be in attendance to discuss these products and assist registrants in any way possible.



Booth	COMPANY and PRODUCTS	Booth	COMPANY and PRODUCTS
103	<b>White-Haines Optical Company, Indianapolis</b>		ment of moderately severe, and malignant cases of hypertension. Orally effective, ANSO-LYSEN inhibits the transmission of nerve impulses through the sympathetic and para-sympathetic ganglia of the autonomic nervous system, reliably lowers the blood pressure, relieves subjective symptoms and is remarkably free from uncontrollable by-effects. Dosage must be individualized. Instruction sheets for use by the patient are available to physicians on request.
52	<b>White Laboratories, Inc., Kenilworth, New Jersey</b>		Also featured will be BICILLIN®, the new, highly insoluble, long-acting penicillin compound, for the treatment and prophylaxis of infections caused by penicillin-sensitive organisms. The unique insolubility of BICILLIN produces prolonged, therapeutically effective blood levels in injectable forms, and in oral forms renders it relatively impervious to the destructive action of gastric juices and penicillinase in the stomach and upper duodenum. Consequently, oral forms are taken without regard to meals. Injectable forms are available in several convenient dosage strengths and combinations.
	James R. Donovan, Richard E. Roeder		* Trademark
	WHITE'S "PHONOSCOPE"—enables you to hear some of the heart sounds commonly encountered in clinical medicine and to see graphically displayed the associated electrocardiograms, carotid artery pulsations and apical stethograms. GITALIGIN (amorphous gitalin) which has been described as a "... digitalis preparation of choice" will be on display.		
47	<b>Wilson Milk Company, Indianapolis 4</b>		
38	<b>Winthrop-Stearns, Inc., New York 18, New York</b>	34	<b>Zimmer Manufacturing Company, Warsaw, Indiana</b>
	Chester Knott, Joseph E. Hartman, Moody Cross, Richard L. McIntosh, Delbert E. Blomgren		F. C. Bartol, C. A. Bartol, Lois F. Bartol
	WINTHROP-STEARN'S, INC., New York, extends a cordial invitation to visit booth No. 38. Featured will be: ALEVAIRE, nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neo-natal asphyxia. MILIBIS SUPPOSITORIES, highly effective specific against trichomonal, monilial, bacterial (mongonococcal) and mixed vaginitis.		Zimmer Manufacturing Company will feature many new items in fracture equipment. Among them will be the explosion proof Luck Bone Saw, the explosion proof Brown Electro Dermatomy, the Robbins Automatic Tourniquet, the Robbins Circlecuf, the new Denis Browne appliances and a complete exhibit of latest fracture equipment and instruments.
54	<b>Wyeth Incorporated, Philadelphia</b>		
	Wyeth will feature ANSO-LYSEN*, new potent ganglionic-blocking agent for use in manage-		

## *Opinions From Here and There*

(Continued)

H.R. 9709 Reed (NY)	Unemployment compensation; redefines employer (Administration bill).	Became Public Law
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### Veterans

H.R. 46 Rogers (Mass)	Lengthening presumption of service connection for tuberculosis (except pulmonary)	Identical bill H. R. 5636 became P. L. 241
H.R. 54 Rogers (Mass)	To authorize appointment of chiropractors in VA.	House hearings held
H.R. 310 McDonough	Lengthening presumption of service connection for tuberculosis (except pulmonary)	Identical bill H. R. 5636 became P. L. 241
H.R. 5636 Radwan	Lengthening presumption of service connection for tuberculosis to 3 yrs.	Became P. L. 241
H.R. 7653 Frelinghuysen	Limiting out-patient dental care for veterans.	Superseded by H. R. 9866 which passed House 8-12-54
H.R. 7711 Fulton	Study of malnutrition among POW and civilian internees.	House hearings held
H.R. 8044 Rogers (Mass)	Grants-in-aid to Philippines for treatment of Philippine veterans.	Became P. L. 421
H.R. 8789 Radwan	Lengthening presumption of service connection for arthritis, multiple sclerosis and psychoses.	Reported 5-12-54
H.R. 9169 Radwan	Lengthening presumption of service connection for multiple sclerosis and psychoses.	Reported 5-20-54
H.R. 9866 Frelinghuysen	Limiting out-patient dental care for veterans.	Reported 7-28-54
H.R. 34 Rogers (Mass)	Investigation of VA by House Veterans Affairs Committee	Passed House 3-5-53 Approp. of \$50,000 voted 3-16-53

### Miscellaneous

S. 977 Smith (NJ)	Removing appropriation ceiling of National Science Foundation.	Became P. L. 223
S. 2245 Bridges	Prohibiting transportation of fireworks.	Similar bill H. R. 116 became P. L. 385
H.R. 116 Church	Prohibiting transportation of fireworks.	Became P. L. 385
H.R. 2341 Wier	Prohibits U. S. and state governments from treating public water with fluoride.	House hearings held
H.R. 4689 Wolverton	Removing appropriation ceiling of National Science Foundation.	Companion bill S. 977 became P. L. 223
H.R. 217 Reece	House select committee to investigate educational and philanthropic foundations.	Passed House 7-27-53 funds voted 8-1-53
H.R. 373 Reece	Providing \$50,000 for tax-exempt foundations study.	Passed House 8-1-53

# HOME LAWN MINERAL SPRINGS

## MARTINSVILLE, INDIANA

Home Lawn Mineral Springs is maintained for those who need to tone-up for the strenuous duties of today's business and social world. All its facilities and all its employees are enrolled with the concern of aiding and administering in every way possible to make a sojourn to Home Lawn profitable from a health standpoint.

The Mineral Baths and treatments are supervised by the Medical Department and given by trained attendants. If diet is indicated or desired you are assured of the best of care and food preparation. You will always be comfortable and at ease while enjoying a health restoration program at Home Lawn.

D. H. KENNEDY, *General Manager*

# HOME LAWN MINERAL SPRINGS

M. C. PITKIN, M.D., *Medical Director*

J. W. GIBBS, M.D., *Associate*



# Deaths . . .

**Charles J. Cook, M.D.**, 87, retired Indianapolis general practitioner, died August 18 in the Veterans Administration Hospital. Although retired because of ill health he had remained active until June 6 when he fell, fracturing a hip. A native of Illinois, he received his medical degree in 1894 from the Medical College of Indiana, interned at City Hospital, Indianapolis, and after practicing briefly in Shelbyville, established his office in Indianapolis. He was an early volunteer for service in World War I and served overseas as a captain in the Army Medical Corps. Dr. Cook was a Fifty Year club and a senior member of the Indiana State Medical Association, member of Indianapolis Medical Society, and of American Medical Association. He had been active in Masonic organizations for more than 60 years.

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**Jesse P. Feagler, M.D.**, retired surgeon, died at the Lutheran Hospital, Fort Wayne, August 20 of cancer of the pancreas. He was 79 years old. Dr. Feagler was a native of Waterloo, where he had been living recently. He practiced in Mishawaka for 30 years but had been in retirement for 21 years, residing in Waterloo, Pomona, California and Mt. Dora, Florida.

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**Edward L. Wiggins, M.D.**, 76, died in Methodist Hospital, Indianapolis, August 11. A graduate of the Medical College of Indiana in 1900, Dr. Wiggins was in general practice in Indianapolis until his retirement 25 years ago. He served as a captain in the Army Medical Corps during World War I. A native of Elwood, Dr. Wiggins had made his home in Indianapolis for many years.

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**James S. Baker, M.D.**, 79, who had been in general practice in southern Indiana for 50 years, died in his Evansville home August 17. A native of Warrick county, Dr. Baker received his medical degree from Louisville Medical College in 1904. He practiced in Spurgeon for 15

years and had been in practice in Evansville for 34 years. He was a member of Vanderburgh County Medical Society, a Fifty Year Club and senior member of Indiana State Medical Association and a member of American Medical Association.

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**Thomas O. Gasaway, M.D.**, 83, a pioneer in radium therapy, died in Williamsport, Pennsylvania, August 22 following surgery. Dr. Gasaway was a native of Flora, received his medical degree from the American College of Medicine in Indianapolis in 1897 and also studied at Johns Hopkins University in Baltimore. Dr. Gasaway practiced in Marion and Terre Haute before establishing an office in Indianapolis in 1907. He operated the Radium Sanitarium until 1927 when he retired. Dr. Gasaway moved to Miami Beach, Florida in 1930.

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**William S. Coleman, M.D.**, retired Rush county physician, died August 22 in Rush Memorial Hospital where he had been a patient since July 26. He had been in ill health for two years. Born in Rush county in 1876, Dr. Coleman received his medical degree from the Medical College of Indiana in 1903 and took advanced training in New York, Chicago and at the Great Ormond Street Children's Hospital, London, England. He practiced in Rushville and during World War I served in France as a medical officer. From 1919 until 1927 he practiced in Miami, Florida. He retired in 1927 but returned to practice temporarily during World War II because of the shortage of physicians. His residence was in Rushville. He was a member of Rush County Medical Society, a Fifty Year Club and senior member of the Indiana State Medical Association.

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**George E. Lowe, M.D.**, 79, retired Indianapolis physician, died August 22 in his home. He had been in ill health for several years, restricting his practice to his office. Born near Noblesville, Dr. Lowe taught school in Hamilton county before entering the Homeopathic

Medical College of Missouri at St. Louis where he received his degree in 1903. He practiced in Indianapolis for 45 years after establishing his office first in Greenfield. Since retiring from active practice, Dr. Lowe maintained an office for some time in the Gray community, near Noblesville. He was a former member of Indianapolis Medical Society and the state association.

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**Nelson B. Combs, M.D.**, 49, died August 28 in St. Elizabeth Hospital, Lafayette. The Mulberry physician had been found four days before with a bullet wound in his right ear. He was vacationing at his Lake Freeman cottage at the time. Dr. Combs was a native of Mulberry, was a 1929 graduate of Indiana University School of Medicine, and served his internship at St. Elizabeth's. He began practice in Mulberry and with the exception of World War II service had remained there. He entered service in 1942, serving as medical officer of the naval flight preparatory school at DePauw University and later as commander and flight surgeon on the carrier Franklin D. Roosevelt. He was a member of Tippecanoe County Medical Society, the Indiana State and American Medical Associations, the American Academy of General Practice and was on the staff of St. Elizabeth and Home Hospitals, Lafayette.

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**Horace N. McKee, M.D.**, 82, former Elkhart physician, died August 28 in his home in Cass County, Michigan, where he had lived for several years. From 1916 until his retirement in 1951, Dr. McKee practiced ophthalmology. He was a member of the Elkhart County Medical Society, a Fifty Year Club and senior member of Indiana State Medical Association and a member of American Medical Association.

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**James A. Taylor, M.D.**, 85, Montpelier physician and surgeon who is believed to be one of the first surgeons to perform a successful appendectomy, died September 4 in his home following a year's illness. He had practiced for 57 years in Montpelier, retiring last January. He had performed surgery until three years ago. Dr. Taylor was a native of Jay county and a graduate of the Medical College of Indiana in

1897. He also did postgraduate study in Chicago. Dr. Taylor was a Fifty Year Club and senior member of the Indiana State Medical Association and a member of the American Medical Association. He had also been an active member of the Masonic order and of Kiwanis.

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**William C. Myers, M.D.**, who had been in practice in Dana for 42 years, died suddenly in his home September 4. Dr. Myers, who had been resident physician at the Wabash River Ordnance Works for several years, had been active in civic affairs in his community throughout his career. He served as a major during World War I. Born in Illinois in 1888, he was graduated from the University of Louisville School of Medicine in 1911. He spent a short time in Tennessee and then located in Dana in 1912. Dr. Myers was a member of Parke-Vermillion County Medical Society, the Indiana State and American Medical Associations.

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**Emmett Earl Rose, M.D.**, 74, who had been in practice on Indianapolis' South Side for 50 years, died at his summer home at Culver September 5. He had been ill since July 20. A native of Indianapolis, Dr. Rose was graduated from the Medical College of Indiana in 1903.

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**Ernest P. Buckley, M.D.**, 64, died September 4 in Clark County Memorial Hospital. He had been a practicing physician in Jeffersonville for 42 years, establishing his office there immediately following his graduation from the University of Louisville School of Medicine in 1912. He was a native of Jeffersonville. Dr. Buckley had been active at all times in medical organizations. He had served as Clark County Medical Society secretary from 1917-1920, in 1930, 1941 and 1943; had been vice-chairman of the Section on Anesthesia of Indiana State Medical Association in 1941 and chairman in 1942 and 1943; had served on several state committees. As a specialist in anesthesiology, he had held office in both the American Society of Anesthesiologists and the international organization. Dr. Buckley had also been active in lodge and civic groups.

## NEWS NOTES—from State and Nation

### Dr. Stone Associated with Indiana State Board of Health

Dr. David F. Stone has been named director of the division of tuberculosis control for the Indiana State Board of Health and has assumed the post which has been vacant for two and a half years. Dr. Merle Bundy was the last director of the division.

Dr. Stone is a 1939 graduate of Indiana University School of Medicine, served for four years in the army, and has been in private practice in Indianapolis with Drs. Russell S. Henry and Edward F. Boyer.

The Muncie Academy of Medicine, probably the oldest postgraduate gathering in the state, will continue this year. Meetings combine a social hour at 5:30 p.m., dinner at 6:30, and a

speaker of national reputation. Meetings are held the second Tuesday of each month, September through May, at the Roberts Hotel, Muncie, and are open to any M.D. Anyone desiring information may be placed on the mailing list by writing Dr. James A. McClintock, 316 West Adams Street, Muncie, Indiana.

Dr. James S. Browning, Indianapolis, was a speaker at the 87th annual meeting of the West Virginia State Medical Association, White Sulphur Springs, on August 20. At the morning general session he spoke on "Some Emotional Factors in Rheumatic Disease". Dr. Browning also spoke to the Section on Neurology, Neurosurgery and Psychiatry, discussing "Some Psychosomatic Factors of Geriatrics." Mrs. Browning accompanied him and they were guests at the Greenbriar for several days.

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### Hospital Receives Microscope As Gustafson Memorial

Members of the Department of Obstetrics and Gynecology of the Indianapolis General Hospital have paid tribute to the memory of Doctor Gerald W. Gustafson by presenting their department with a microscope inscribed as the "Doctor G. Gustafson Memorial Microscope". The resolution by which they created the memorial calls attention to the many years of unselfish service which Dr. Gustafson gave as a member of the staff, and to the high esteem in which he was held by his fellow physicians, by his students and by his patients.

**Dr. James J. Sullivan**, 1953 graduate of I. U. who recently completed his internship at Municipal Hospital, Tampa, Florida, is practicing temporarily in the offices of the late Dr. C. E. Linton in Medaryville. Dr. Sullivan expects to be called for duty in the Army Medical Corps during the next year. He is a native of Royal Center.

**Dr. Robert W. Currie**, who has been in private practice in Marion, has purchased a combined residence and office at 512 East 57th Street (at Central) in Indianapolis where he will specialize in diagnostic and therapeutic radiology. He is board certified. Remodelling of his office was expected to be completed early in October. Dr. Currie is a native of Tipton county, a 1935 graduate of I.U. School of Medicine, interned at Methodist hospital, Indianapolis, served a two-year residency at Ford Hospital, Detroit, and then returned to Methodist for a year's residency in pathology. He was associate internist at Billings Clinic, Billings, Montana, two and a half years, then served four years in the army medical corps as a radiologist. He served a residency in radiology at St. Elizabeth Hospital, Lafayette, and returned there for a year as fulltime radiologist after completing a fellowship in radiology at Memorial Hospital, New York. When Dr. Currie first went to Marion he served as part-time radiologist for the VA Hospital and for Mercy Hospital, Elwood, before going into private practice. He is married and the father of four children.

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### ACS Announces 1955 Sectional Meetings

Six sectional meetings of the American College of Surgeons have been scheduled for 1955 according to a September announcement from Dr. H. Prather Saunders, associate director, 40 East Erie Street, Chicago 11, Illinois. Complete data may be obtained from Dr. Saunders.

Meetings will be held in Galveston, Texas, January 17-19; Cleveland, Ohio, February 21-24; Providence, Rhode Island, March 3-5; Nashville, Tennessee, April 4-6; Sun Valley, Idaho, April 18-20; and in Winnipeg, Manitoba, April 25-26.

**Commander Robert E. Switzer, MC, USN**, of Cromwell, was recently promoted to that rank and relieved of his duties as acting chief of service and training officer for the Neuropsychiatric Service at U. S. Naval Hospital, National Naval Medical Center, Bethesda, Maryland, and was assigned as Chief of Neuropsychiatry, U. S. Naval Hospital, Portsmouth, Virginia.

**Dr. Herschel C. Moss**, Indianapolis, is serving a year's surgical residency at Roswell Park Memorial Institute, Buffalo, New York. He will return to Indianapolis to resume his practice on completion of the year's training.

### Southern Medical Association Announces St. Louis Meeting

The 48th annual meeting of the Southern Medical Association will be held in St. Louis from November 8 through 11, according to an announcement by Dr. Alphonse McMahon, president. Meetings will be held in Kiel Auditorium.

Forty-eight separate half-day sessions will be held by the various sections. There is no registration fee.

**Dr. D. S. Houser**, who has completed a three year residency in Cook County Hospital, Chicago, will continue in practice at the Riley Road Clinic, Lakeville, where he will specialize in obstetrics and gynecology.



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### **Postgraduate Courses Offered by Chicago Society**

The Chicago Medical Society has announced two postgraduate courses to be held in November. Basic Principles and Recent Developments in Internal Medicine is to be the subject of a course running from November 8 to 12. Basic Principles and Recent Developments in General Surgery will be discussed from November 15 to 19. All meetings will be conducted in the Sheraton Hotel. Registration is limited to 100. The fee for each course is \$75.00, which includes luncheon tickets, morning and afternoon refreshments and a booklet containing a summary of each lecture. Applications for enrollment should be sent to the Chicago Medical Society, 86 E. Randolph Street. Checks should be made out to Chicago Medical Society and mailed to Lowell T. Coggeshall, M.D., at the same address.

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**The Arthritis and Rheumatism Foundation** of Cleveland is sponsoring a conference on rheumatic disease, to which all interested physicians are invited. The place of meeting is the Hotel Carter, Cleveland, Ohio. Time is November 10, from 9 a.m. to 5 p.m. The registration fee is \$10.00. Inquiries may be addressed to William S. Clark, M.D., 2073 Abington Road, Cleveland 6.

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### **Civil Service Accepting Medical Officer Applications**

New examinations have been announced by the U. S. Civil Service Commission for filling Medical Officer positions in certain Federal agencies as follows: Positions of Medical Officer, paying \$5,940 and \$7,040 a year and Medical Officer (Specialist), paying \$8,360 to \$10,800 a year, will be filled in various agencies in Washington, D. C., and vicinity, and in the U. S. Public Health Service and the Children's Bureau, located throughout the United States. Positions of Medical Officer paying \$7,425 to \$10,450 a year, will be filled in the Panama Canal Company-Canal Zone Government Organization in the Panama Canal Zone. Applications for all positions will be accepted until

further notice. Applications for positions in agencies in the United States must be filed with the Commission's Washington office. For positions in the Panama Canal Zone, send applications to the Board of U. S. Civil Service Examiners, Balboa Heights, Canal Zone.

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### **College of Surgeons to Meet in Atlantic City**

The largest and most widely instructive meeting of surgeons in the world, the 40th annual Clinical Congress of the American College of Surgeons, will be held in Atlantic City, New Jersey, November 15 to 19. More than 10,000 Fellows of the College and their guests from all over the world will attend. This postgraduate education meeting will present recent surgical developments through a wide variety of programs, including panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television and exhibits. Dr. Charles deT. Shivers, Atlantic City, is Chairman of the Atlantic City Advisory Committee on Arrangements.

Dr. Frank Glenn, New York, current President of the American College of Surgeons, will preside at the opening evening session, at which Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York, will be guest speakers. On the final evening Dr. Alfred Blalock, Baltimore, will be installed as President for the coming year.

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**Dr. Bill E. Freeland** has returned to re-establish his practice in Batesville after serving 18 months in military service. His office at 8 West Boehringer street was reopened August 1. Mrs. Freeland and their two daughters expect to join him when living quarters are available. With the return of Dr. Freeland, Batesville now has five doctors.

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**Dr. Richard E. Lahr**, native of Mishawaka, has established his office and residence at 1121 West Third street, Marion, where he has begun the general practice of medicine. He is a 1949 I. U. graduate, interned in Toledo and is a veteran of the U. S. Navy Medical Corps.

### Indiana Physicians Given Recognition by A. M. A.

Four Hoosier physicians were honored by various clinical sections of the A.M.A., this summer, at the annual meeting in San Francisco.

Dr. Hugh A. Kuhn of Hammond was elected as secretary of the Section on Laryngology, Otology and Rhinology.

Dr. Lester D. Bibler, Indianapolis, was selected by the Section on General Practice as the section's delegate to the A.M.A. House of Delegates.

Dr. Lall G. Montgomery, Muncie, was similarly selected as delegate by the Section on Pathology and Physiology.

Dr. Harris B. Shumacker, Indianapolis, was chosen by the Section on Surgery, General and Abdominal, as its representative on the American Board of Surgery.

Dr. James C. Katterjohn, Indianapolis, has returned from South America where he delivered two papers before the Sixth International Cancer Congress at Sao Paulo, Brazil. Fifty-four countries were represented at the Congress. Dr. Katterjohn's papers were: "Three-Fold Irradiation Technique in Treatment of Cervix Cancer" and "The Radiologist's Role in Carcinoma of the Breast".

Dr. Frank C. Waltz is now practicing in the office of the late Dr. W. C. Matthew in Kentland. Mrs. Waltz, a registered laboratory technician, is assisting him. Dr. Waltz is a 1950 graduate of I. U. School of Medicine, interned in Salt Lake City and has been practicing in Bicknell. He is a native of Hagerstown.

A combined office and residence at 615 North College, Bloomington, is being occupied by Dr. Paul W. Holtzman. Dr. Holtzman is a native of Gosport, graduate of I. U. School of Medicine in 1947, served his internship in Youngstown, Ohio, and then spent four years in residency at Indianapolis General Hospital. He has just completed two years' military service with the Army Medical Corps in Germany. Mrs. Holtzman is the daughter of Dr. Fred Dukes, Dugger.

Dr. Bertram W. Sanders, who recently completed his internship at Indianapolis General Hospital, has joined his father-in-law, Dr. V. J. Fruth, and his brother-in-law, Dr. Rodney B. Fruth, in the practice of medicine at 634 Eastern avenue, Connersville. Dr. Sanders served for three years in Europe during World War II. He has since graduated from Earlham College and received his medical degree from George Washington University School of Medicine, Washington, D. C.

### Gamma Globulin Available Directly to Physicians

The Office of Defense Mobilization has announced that supplies of gamma globulin will be available through normal drug channels effective October 1. It will be marketed under the name "Polio Immune Globulin (Human)". It is suitable for modification of measles and infectious hepatitis, as well as for prevention of paralytic poliomyelitis.

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### Hill-Burton Hospital Construction Report Issued

No new projects have been approved for Indiana according to the July 31 report of the Division of Hospital Facilities, FSA. The report shows that 38 projects providing 1,767 additional hospital beds have been completed and are in operation. Total cost of these projects was \$29,628,706 including the federal contribution of \$11,551,378.

Still incomplete are 5 other projects which will cost \$14,078,223 and supply 431 additional beds. Federal contribution is \$4,849,900.

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**Dr. S. W. Martin** is associated in general practice with Dr. W. J. Brockman, Corydon. He came to Corydon May 1 after serving as resident physician at Grace Memorial Hospital, Banner Elk, North Carolina. Drs. Brockman and Martin were classmates at the University of Louisville where they received their medical degrees in 1949. Dr. Martin interned at General Hospital, Knoxville, Tennessee, then served two years in the army, 14 months of which was in Korea. Mrs. Martin is a native of Georgetown. They have two children.

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**Dr. Clarence G. Clarkson**, graduate of the University of Cincinnati School of Medicine, was scheduled to open his office for the general practice of medicine in Liberty on October 1. He completed his internship in June at the U. S. Public Health Service Hospital, New Orleans. He has purchased a home at 304 East Union Street, Liberty, and will establish his office there. An Air Force veteran of World War II, Dr. Clarkson is married and has two children.

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**Dr. Robert M. Clark**, who received his medical degree from Northwestern University Medical School in 1952 and served internship and residency at Cook County Hospital, Chicago, is now associated with Drs. Joseph H. Clevenger and Stanley W. Burwell at 424 West Jackson street, Muncie. He is a native of Muncie and served for two years in the Army before entering medical school.

**Dr. M. Jack Powell** is now associated with Dr. C. H. Warfield in the practice of radiology in St. Joseph's Hospital, Fort Wayne. Dr. Powell is a native of Pittsburgh, received his M.D. at Hahnemann Medical College in 1943 and interned at Shadyside Hospital, Pittsburgh. He was in the Navy Medical Corps for two years, in private practice for three years and then returned to Hahnemann Hospital for a three-year residency in radiology. He is certified by the American Board of Radiology. Dr. and Mrs. Powell and their three children live at 4314 South Calhoun street, Fort Wayne.

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**Dr. Maurice S. Fox**, Vincennes, has been appointed a member of the Indiana State Board of Medical Registration and Examination succeeding Dr. Hobart C. Ruddick, who resigned. Dr. Fox will serve until April, 1956.

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**Dr. Douglas A. Bailey** has begun general practice of medicine at 107 East 31st street, Marion, in offices formerly occupied by Dr. Robert McIlwain. Dr. Bailey was formerly associated with the Mathiesen Clinic, Pittsboro, North Carolina. He will be joined later by his brother, Dr. Donald Bailey, who is completing postgraduate training in California.

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**Dr. Howard M. Luginbill** has opened his office for the general practice of medicine in Berne, where he formerly resided. He has been in practice in South Bend since March, 1954, when he was discharged as a first lieutenant in the Army Medical Corps. Dr. Luginbill was in service before entering medical school. He received his degree in 1950, interned for one year at Memorial Hospital, South Bend, then entered the private practice of medicine there. He was recalled as a physician after being in practice 18 months. Dr. Luginbill's office is on South Jefferson street, Berne, and his residence on West Main Street. Dr. and Mrs. Luginbill have two children.

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**Dr. D. M. Reynolds**, who has been in practice for 54 years, has moved his office from 108 East Keyser street, Garrett, to his residence at 600 East King street. He will do a limited practice by appointment only when his health permits.



### Details of Van Meter Prize Award Are Announced

The American Goiter Association again offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association which will be held in Oklahoma City, Oklahoma, April 28, 29 and 30, 1955, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English, and a typewritten double space copy in duplicate sent to the Secretary, John C. McClintock, M.D., 149½ Washington Avenue, Albany, New York, not later than January 15, 1955. The committee, which will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the

Prize Award Essay by the author, if it is possible for him to attend. The essay will be published in the annual proceedings of the association.

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**Dr. Louis R. Salmon**, native of New York City, has joined the staff of the Wabash Clinic where he will do general practice and assist Dr. William Dannacher in surgery. He recently completed his internship at Wayne County General Hospital, Eloise, Michigan. Dr. Salmon received his medical degree from New York University College of Medicine, New York City. He is a Marine Corps veteran.

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**Dr. Wesley E. Shannon** has opened an office for the general practice of medicine in Crawfordsville at 901 Cottage Avenue. He is a graduate of I. U. School of Medicine and interned at St. Elizabeth Hospital, Lafayette. Dr. and Mrs. Shannon and their two sons reside at 507 Russell Avenue, Crawfordsville.

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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

August 22, 1954

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M. D.; Walter L. Portteus, M. D.; Elton R. Clarke, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump and Robert Hollowell, attorneys; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

### Membership Report

Number of members August 20, 1954 ----- 3,827\*  
 Number of members August 20, 1953 ----- 3,723  
 Gain over last year ----- 104  
 Number of members December 31, 1953 --- 3,822

\* Includes 128 in military service (gratis)

106—\$10.00 members (residents and interns)  
 265—senior members  
 63—members, dues remitted by Council  
 2 honorary members

### AMA dues paid:

1952 ----- 3,569  
 1953 ----- 3,628\*\*  
 1954 ----- 3,573\*\*

\*\* Includes 420 members permanently exempted in 1952

### Headquarters Office

The field secretaries, Mr. Amick and Mr. Bush, reported on their activities, stating that they had been busy calling upon candidates for the coming session of the State Legislature and completing the records as was desired by the Executive Committee.

### Legislative Matters

#### Local

The legal counsel, Mr. Hollowell, reported on his findings relative to the proposed amendment to the Constitution of the State of Indiana and following discussion, by consent it was agreed that the attorney should prepare a letter to the League of Women Voters and the Chamber of Commerce, to go out over the Association name, explaining the position of the Association in this matter and asking certain questions.

Statements of Receipts and Expenditures for

July for the Association and *THE JOURNAL* were accepted by consent.

### Annual Convention, Indianapolis, October 24, 25, 26 and 27, 1954:

By consent it was agreed that Dr. Homer G. Hamer should be requested to give the response on behalf of the Fifty-Year Club.

By consent it was agreed that Dr. J. William Wright, Sr., should be requested to have charge of seating the wives of those at the speakers' table, past presidents, councilors and their wives at the annual banquet during the convention.

Upon motion of Drs. Portteus and Clarke, the secretary was instructed to purchase general liability insurance covering the period of the 1954 convention.

The secretary reported that a request had been received from Dr. J. L. Arbogast, chairman of the Committee on Scientific Exhibits, in which he stated the committee was desirous of awarding three awards to the first, second and third best exhibits in the scientific section and the awards were estimated to cost \$100.00. It was stated that he was desirous of a secret committee being named to make the selection of the exhibits. Upon motion of Drs. Portteus and Clauser, the committee agreed to allow the Committee on Scientific Exhibits \$100.00 for the purchase of awards.

Upon motion of Drs. Portteus and Clarke the president is to be requested to appoint a secret committee consisting of a general surgeon, a general practitioner, and a laboratory man to comprise the secret committee to select the winning scientific exhibits.

### Organization Matters

A letter was read from the Medical Library Association, soliciting the sum of \$150.00 for scholarships for medical library technicians. Upon motion of Drs. Portteus and Clauser the request was tabled.

Upon motion of Drs. Clauser and Portteus the president and the executive secretary were authorized to attend the annual meeting of the Wisconsin State Medical Society, the Kentucky State Medical Association, and the Michigan State Medical Society.

Authority was also granted the president-elect to attend the Kentucky State Medical Association meeting.

An invitation from the Indiana State Chamber of Commerce for a representative of the Association to attend their annual meeting at French Lick was read, and upon motion of Drs. Clarke and

Clauser the president is to be requested to represent the Association at this meeting.

Invitation of the Fifth National County Medical Societies Civil Defense Conference, to be held in Chicago, October 30-31, 1954, was read, and upon motion of Dr. Clarke and Dr. Clauser, the secretary was instructed to notify the county medical societies of this meeting and urge that they have a representative attend this meeting. It was also a part of the motion that the president-elect should select someone to represent the Indiana State Medical Association at this meeting.

The secretary reported on the closed showing of the new television program called "Medic" which will make its debut on a nationwide broadcast on September 13, the secretary explaining that it was sponsored by the Dow Chemical Company and was very good in its content and he felt it would do much to improve the public relations of the medical profession, particularly bringing about a better understanding on the part of the public of the problems of modern-day medicine.

### The Journal

*Report on advertising* was accepted by consent:

Total, September, 1954	-----	\$2,674.75
Total, September, 1953	-----	2,171.91
Net gain	-----	\$ 502.84

### New Business

The secretary reminded the committee of the Burney appreciation dinner to be held at the Columbia Club, Indianapolis, Wednesday evening, August 25, 1954.

### Future Meetings

American Public Health Association, Buffalo, October 11 to 15, 1954.

American Medical Association Interim Meeting, Miami, November 28 to December 5, 1954.

There being no further business the committee adjourned to meet again at 11:30 a. m. on Sunday, September 26, 1954, in the Conference Room of the Student Union Building of the Indiana University School of Medicine, Indianapolis.



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# The *Journal*

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## Regional Enteritis\*

RICHARD A. SILVER, M.D.

*Muncie*

**R**EGIONAL ILEITIS is a term originally coined by Crohn<sup>1</sup> in 1932 to describe a clinical and pathologic entity involving a segment or segments of the small bowel. It is known by several synonyms — regional enteritis, regional ileitis, terminal ileitis and ileo-colitis. These are used interchangeably. Prior to 1932, patients with the disease had been variously diagnosed as tuberculosis of the bowel, amebic granuloma, neoplasm or ulcerative ileo-colitis. The relative newness of this concept, plus the fact that it is infrequently encountered in general medical or surgical practice, has led many to consider it rare. However, in a hospital pathological or radiological laboratory, such cases eventually are seen for purposes of diagnostic tests or treatment. Our experience has been that, although not common, it does occur frequently enough that it warrants consideration in the differential diagnosis of all cases presenting themselves with obscure abdominal complaints.

Since Crohn's original description the number

of references in the literature has rapidly increased. By 1939 Crohn<sup>2</sup> had collected 110 cases in the preceding six years and believes its incidence at least half as great as nonspecific ulcerative colitis. Rossmiller<sup>3</sup> at the Cleveland Clinic reported 55 cases between 1934 and 1946. In our study we found a total of 20 proven cases occurring in a period of six years in a 500 bed hospital.\*\* At Ball Memorial Hospital we have encountered 7 proven cases in the past two years.

It is the purpose in this report to briefly describe the classic clinical symptomatology and illustrate the roentgen and pathologic findings in the disease. Those interested are referred to the literature for discussions of history, etiology and treatment.<sup>4, 5, 6</sup>

As originally described regional enteritis is a nonspecific inflammatory disease affecting mainly young adults and characterized by an acute, a subacute, and a chronic phase of necrotizing, ulcerating and cicatrizing inflammation. Associated with it are partial or complete intestinal obstruction, fistula formation or rectal suppurative conditions. It is seldom found in a well nourished individual. It presents many and varied symptoms which have been nicely classified

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\* Revised version of paper presented at French Lick, October, 1953 at annual convention of Indiana State Medical Association.

\*\* Rochester General Hospital, Rochester, New York.

by Bockus<sup>4</sup> into various syndromes, as follows:

TABLE 1

SYMPTOM COMPLEXES OF  
REGIONAL ENTERITIS

1. ULCERATIVE COLITIS SYNDROME
2. INTESTINAL OBSTRUCTION SYNDROME
3. SYMPTOMS OF ACUTE APPENDICITIS
4. ABDOMINAL PAIN
5. FEVER OF UNDETERMINED ORIGIN
6. NUTRITIONAL DEFICIENCY
7. SYMPTOMS DUE TO BOWEL PERFORATION

1. *The ulcerative colitis syndrome.* In these the symptoms mimic those of ulcerative colitis clinically. Diarrhea begins as occasional intermittent bouts and gradually becomes a daily occurrence. As a rule it is not severe, three to four bowel movements daily, with a fairly well formed stool. In the more advanced cases, there is often mucus, pus or blood in the stool. Intermittent crampy abdominal pain is a frequent complaint. It differs from the similar pain of ulcerative colitis in that bowel movement does not relieve it, as is generally true in chronic ulcerative colitis. Pain is often brought on by eating, and there is usually progressive weakness and loss of weight. In differentiating between ulcerative colitis and ileitis, the lack of X-ray finding of colitis, and the lack of tenesmus which is so prominent in colitis should lead one to suspect ileitis.

2. *Intestinal obstruction syndrome.* This is the second most common symptom complex seen in ileitis and will be seen in about one-fifth of cases. Usually the patient presents complaints of severe colicky pain, vomiting and distention. A palpable mass is often found and visible peristalsis observed. Any young patient with a long history of intestinal complaints, who is partially or completely obstructed, and has a palpable mass, probably has regional ileitis.

3. *Symptoms of acute appendicitis* including right lower quadrant pain and fever, leukocytosis, and occasionally nausea and vomiting. This is particularly true in the acute forms, in which case differentiation from acute appendicitis is virtually impossible.

4. *Abdominal pain alone.* This pain may be in any part of the abdomen and is usually intermittent.

5. *Fever of undetermined origin,* particularly when accompanied by chronic abdominal pain.

6. *Nutritional deficiency.* These are often very severe cases and simulate deficiency states such as pellagra, sprue and nutritional edema. Sprue is often difficult to differentiate from ileitis, because sprue may give no typical roentgen picture and at times the findings may be identical to those of regional ileitis. However, a differential point is the absence of splenomegaly or an enlarged liver in regional ileitis.

7. *Symptoms due to bowel perforation.* Thirty to fifty per cent of cases of regional enteritis will have a palpable mass in the right lower quadrant. Usually it is not as hard and nodular as carcinoma, but may be ill defined and hose-like. The differential diagnosis includes pelvic inflammatory disease, appendiceal abscess, tuberculous abscess, carcinoma of the caecum, perinephric abscess and regional enteritis.

Other symptoms and findings (Table 2) which occur are those of internal fistula, external fistula, anemia and mild bleeding, perforation with peritonitis, peri-anal and peri-rectal fistulas, psychoneurosis, pigmentation of the skin, particularly the lower extremities, and clubbing of the fingers. These occur alone or in various combinations.

## ROENTGEN FINDINGS

The typical and atypical roentgen findings (Table 3) which may lead to a diagnosis of ileitis may be grouped as follows: 1) *The string sign of Kantor* which is somewhat of a misnomer in that a real string is not often found and the findings of it are not pathognomonic. 2) *Fill-*

TABLE 2

MISCELLANEOUS FINDINGS

1. INTERNAL AND/OR EXTERNAL FISTULA
2. PERFORATION WITH PERITONITIS
3. PERI-ANAL AND PERI-RECTAL FISTULA
4. PSYCHONEUROSIS
5. PIGMENTATION OF SKIN
6. CLUBBING OF FINGERS

TABLE 3

ROENTGEN FINDINGS

1. "STRING SIGN"
2. FILLING DEFECTS IN THE ILEUM
3. DILATATION OF THE ILEUM
4. "HERON-BEAK" SIGN
5. TEAT-LIKE DEFECT IN CECUM
6. CONCAVE DEFORMITY OF MEDIAL CECAL WALL
7. DELAY IN EMPTYING OF THE SMALL BOWEL

ing defects in the ileum. 3) *Dilatation of the ileum.* 4) *The "Heron-Beak" sign*, which is caused by a narrowing of the terminal ileum with dilatation proximal to the constricted segment forming the beak and head of a bird or heron. Bockus found this unusual configuration in three of twenty cases. 5) *A teat-like defect in the caecum.* 6) *A concave deformity of the medial caecal wall*, and 7) *Delay of emptying of the small bowel.* These findings may occur together or separately. None is pathognomonic; those found must be carefully correlated with the clinical history before a diagnosis of ileitis is warranted.

(Fig. 1) The string sign results from scarring of the bowel wall with contracture and consequent narrowing of its lumen. The "string" is limited to the involved area and may vary from a few to several centimeters in length.

With ulceration and contracture, the normal mucosal pattern is lost. Irregular scarring produces a nodular cobblestone-like surface on the mucosa which is seen on X-ray as multiple radio-lucent filling defects in the ileum replacing the normal mucosal pattern. Proximal to the diseased area, the ileum becomes dilated. The degree of dilatation varies, of course, with the degree of obstruction present below it. With slowly developing obstruction, the entire small bowel may be dilated. This will be seen either on plain films or after ingestion of barium.

Another roentgen finding is produced by narrowing of the ileum in the involved segment plus dilatation immediately above the constricted segment. This has been likened in appearance to a bird's head, and hence called the "heron-beak" sign; the constricted segment forms the beak and the dilated portion the head.

Other roentgen findings include filling defects in the cecum when the terminal ileum is involved. They may be seen as teat-like defects of the caput of the cecum, or as concavities in the medial cecal wall at the ileocolic valve.

### GROSS PATHOLOGY

Grossly, the site of involvement is usually in the last few inches of terminal ileum, just proximal to the ileo-cecal valve. However, any portion of the small bowel may be involved.



Fig. 1. Narrowing of terminal ileum in regional enteritis

The lumen of the involved bowel is markedly narrowed so only a thin "string" of barium passes through it. Note the loss of normal mucosal pattern, and the relatively low position of the heavy, edematous diseased terminal ileum.

The occurrence of "skip areas" is notorious, where one finds several separate segments of bowel involved. These are one or more inches long, terminate abruptly, with normal gut interspersed between each involved segment. One of our cases had five such "skip areas" of diseased bowel, besides the terminal ileum.

The unopened involved bowel is edematous, thickened, and quite rigid. The overlying mesenteric fat is much thicker than normal, and the mesenteric lymph nodes draining the area are enlarged, firm and rubbery in consistency. The thickening of the mesenteric fat is limited to the involved segment and terminates abruptly as the ileum becomes normal. This is sometimes of value to the surgeon in determining how much ileum to resect. The nodes never calcify, caseate or necrose, a differential point in diagnosis of ileitis and tuberculosis.

Upon opening the bowel, it is found to have a tremendously thickened wall and the lumen is





Fig. 2. Resected terminal ileum and cecum in regional ileitis

The bowel has been opened longitudinally. Note the thickened wall and consequently narrowed lumen. The thickened mesenteric fat is also seen. This thickening ends abruptly at the same point as does the involvement of the ileum by disease. This is sometimes a guide to the surgeon in determining how much ileum to resect.

consequently narrowed or completely obstructed. (Fig. 2) The mucosa shows varying degrees of hyperemia, edema, necrosis and ulceration.

There are also varying degrees of ulceration and contracture scarring of the mucosa, dependent somewhat on the stage of the disease. This results in irregular scarring and produces the cobblestone-like surface which may be demonstrated by x-ray examination.

The portion of ileum just proximal to the ileocolic valve is most apt to show ulceration and any such ulcer may be penetrating. When it does penetrate, fistula and perforations develop. These are accompanied by inflammatory exudates, and sizeable granulomatous masses may form. (Fig. 3) When subacute perforations occur, abscesses are not uncommon.

## SUMMARY

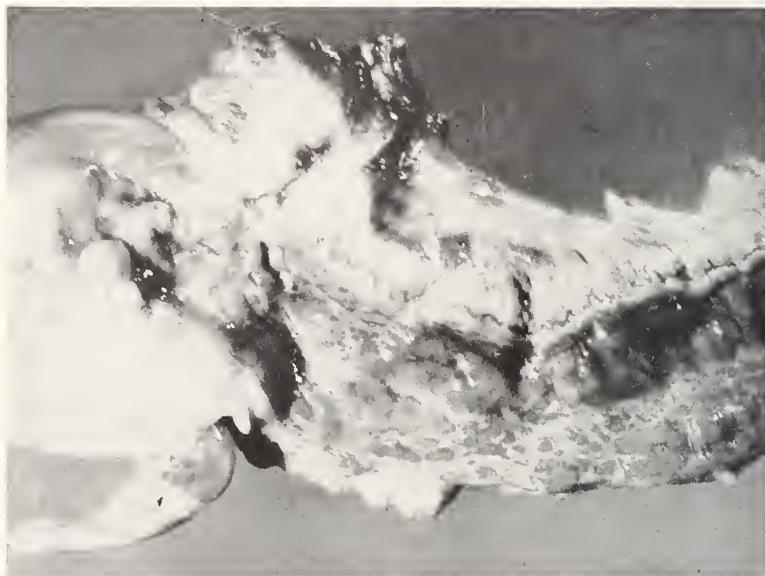
Regional enteritis is a non-specific inflammatory process involving the small intestine, usually the terminal ileum, characterized by granuloma formation, ulceration and cicatrization. It occurs frequently enough that it may be considered in every case of obscure abdominal complaints. Its symptoms, roentgen findings, and gross pathology have been briefly illustrated and discussed.

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Fig. 3. Regional ileitis with subacute perforation

This close-up includes the terminal ileum with adjacent cecum and attached appendix. Note the perforation opposite the appendix, about which a mass of granulomatous scar tissue has formed. The cobblestone-like pattern of the involved mucosa is also seen.



**Discussion by Lall G. Montgomery, M.D.**  
**of the paper "Regional Enteritis" by**  
**Richard A. Silver, M.D., Muncie**

Doctor Silver has given us a helpful discussion of a timely subject. Until quite recently regional enteritis was thought to be a rare disease, but the fact is that almost any of us may see a case almost any time. I asked a group of 12 pathologists from various parts of the state how many of them had seen cases of regional enteritis in the past 2 years—six of the 12 had seen 13 cases, and one had seen 7 cases.

It should be noted that Doctor Silver used the modern terminology "regional enteritis" rather than "regional ileitis" as it was first called. This points up the fact that this lesion may affect almost any part of the gastro-intestinal tract. Thus, just because a lesion is not found in the terminal ileum, in no way rules out "regional enteritis" as a possible diagnosis. As an example, we have seen several cases in which the lesion was limited to the appendix, either alone, or together with the cecum.

On the other hand, segmental chronic inflammatory lesions of the bowel may not be regional enteritis. Recently Shields Warren has described the pathologic differences between the lesions of regional enteritis and those of thrombo-ulcerative colitis which have heretofore been confused. This has added another important

entity to the differential diagnosis of stenosing lesions of the bowel.

Unfortunately, all too often the differential diagnosis of a case of regional enteritis must be considered after the abdomen has been opened, which makes it all the more important for us to have this condition well in mind.

Several months ago we saw a case of a 19 year old girl with abdominal pain and a lower abdominal mass. The fact that she was several months pregnant added a number of possibilities to the differential diagnosis. However, when she was opened she had a mass in the mid-ileum which was so circumscribed that it was thought to be a tumor, but which turned out to be a segment of regional enteritis with a perforation and a mesenteric abscess.

It is fortunate that Doctor Silver and his confreres can give us so much preoperative radiologic assistance, but since about 50 percent of these cases are thought to be appendicitis, all too often the radiologist has no opportunity to give his help. Another difficulty seems to be the fact that since most cases of regional enteritis affect the small bowel the radiologist has certain technical difficulties to face in making his examination.

---

*An Abstract:*

**OCULAR PALSY AS A COMPLICATION OF DIABETES**

Paralysis of an ocular muscle is one of the rarer complications of diabetes. The author reports a case of his own and reviews the available literature. It appears most commonly during the first three years of the disease. The relative frequency of the cranial nerve involvement is the sixth, fourth and third. A British writer feels that in sixth nerve paralysis, diabetes should be immediately thought of if syphilis has been ruled out. Recovery is slow, usually occurring within two or three months but at times requiring a year. The lesion is generally felt to be on a vascular basis. Treatment is management of the diabetes and prevention of diplopia by occluding one eye.

Feldman, Noah, M.D.: Ocular Palsy as a Complication of Diabetes. J. M. Soc. New Jersey. 51:379, Sept. 1954

# Carcinoid Tumors of the Rectum With a Case Report

E. L. FITZSIMMONS, M.D.

RAY H. BURNIKEL, M.D.

*Evansville*

**D**URING THE PAST SEVERAL years, carcinoid tumors of the rectum have been reported with increasing regularity, but they still remain a rare type of tumor. Similar tumors of the gastro-intestinal tract have been widely reported, however, the majority of these either are in the ileum or the appendix. A search through the literature reveals there have been reported a total of only 103 cases of rectal involvement up to 1953.<sup>13</sup> It is interesting to note that 92 of these 103 cases have been reported during the past 12 years. Carcinoid tumors are primary neoplasms of the gastro-intestinal tract which may occur at any point from the stomach to the rectum. They are interesting because of their gross and histo-pathologic characteristics, which have led most investigators to regard them as benign, and yet they may at times fulfill all of the requirements of a malignancy by manifesting metastasis. It is our desire in this paper to briefly review some of the literature and to report what we consider to be the 104th case of carcinoid of the rectum.

## GENERAL REVIEW

Credit is usually given to Lubarsch<sup>5</sup> who in 1888, presented two cases of ileo carcinoids, which were multiple and non-metastasizing. He termed these "little carcinomata" and described them well enough to be considered adequate for identification purposes. He traced the tumors to an epithelial origin and considered the crypts of Lieberkühn as the site of their derivation.

The term, carcinoid tumors, was originated by Oberndorfer<sup>8</sup> in 1907. He believed these tumors to be benign and stated that they were slow in growth, generally small and non-metastatic.

He offered, however, no theory as to their origin. The histogenesis of these tumors is still somewhat in doubt. The most general accepted theory is that they have their origin in the cells of Kultschitsky, which are located at the base of the crypts of Lieberkühn. The cells of Kultschitsky are sometimes known as the basi-granular, chromaffin, or enterochrome cell.

Masson<sup>6</sup> was of the opinion that carcinoids began in neuromas by proliferation of intraneural argentaffin cells or neurocrine type cells, which in turn originated from the cells of Kultschitsky in the depths of the crypts of Lieberkühn.

Popoff<sup>9</sup> believed that the argentaffin cells were actually mucous cells which had reached a stage of functional exhaustion and then were rejuvenated by a "cytomorphic process" during which they acquired silver reducing granules. He stained the carcinoid cells with ammoniac silver nitrate and showed that the intracytoplasmic granules of the tumor cells had the ability to reduce the silver ion to free silver.

Stout<sup>12</sup>, however, suggested that these tumors arose from the pre-enterochrome cells of Ers-pamer, because of the unusual arrangement of the cells in five of his six cases of rectal carcinoid; and also because the cells seldom contained silver reducing granules.

Grossly, most rectal carcinoids are small submucosal nodules. They may be either sessile or polypoid. They are, as a general rule, solitary lesions, however, Rigdon<sup>11</sup> and Fletcher reported multiple carcinoids in which the tumors infiltrated a segment of rectum 15 cm. in length.

Most rectal carcinoids remain in size between 0.5 to 1.5 cm., although large ones have been re-



ported. It is the feeling of Mrazek et al.<sup>7</sup> that malignancy depends upon the size of the lesion and that those lesions which are larger than 2 cm. should possibly be considered as malignant and having the possibilities of metastasizing.

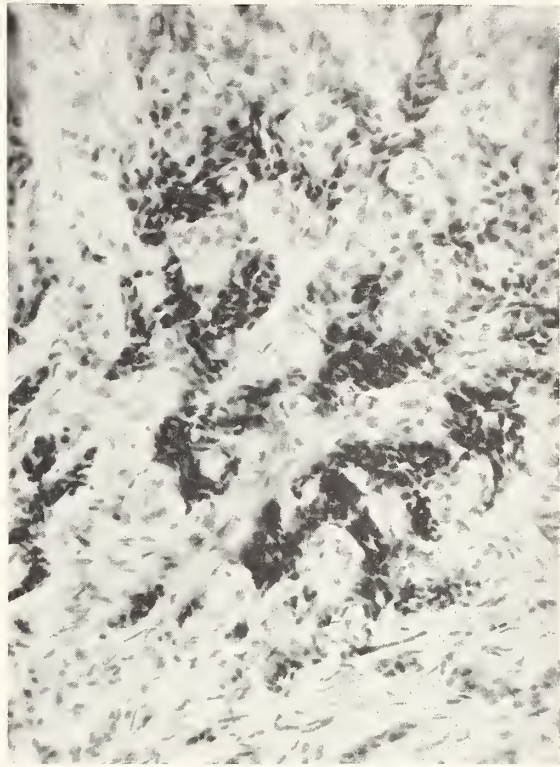
Stout<sup>12</sup> thought that he could tell the difference histologically, between rectal and other types of carcinoids. Kunkel, et al.<sup>4</sup> stated that rectal carcinoids are not significantly different, histologically, from ordinary appendiceal carcinoids. Rigdon<sup>11</sup> has stated that growth is extremely slow even when metastasis has occurred. Of the reported 103 cases of carcinoids of the rectum, 14 or 13.5% have been malignant.<sup>7</sup> It is interesting to compare these figures with those by Ritchie and Stafford<sup>10</sup>, who found that of 332 cases of carcinoid tumors from all sites reported in the literature up to 1944, 126 or 37.9% had shown metastasis.

Metastasis from carcinoid of the rectum spreads through the rectal wall into the regional nodes and thence to the liver and occasionally elsewhere. While it is generally agreed that growth from a carcinoid is slow, Horn<sup>2</sup> described a patient with a rectal carcinoid who lived only three months after the onset of symptoms.

Rectal carcinoids usually occur in patients who are in the cancer age, which is usually considered between the ages of 30 to 70. Kunkel<sup>4</sup> has stated that there is no sex predilection. However, Tavenner<sup>13</sup> has stated that the tumors occur slightly more frequently in the female patient than in the male.

Pathologically speaking, these carcinoid tumors are generally described as having a small epithelial cell with a round or oval nucleus. The nuclei are generally uniform and may contain small nucleoli and punctate chromatin throughout the cytoplasm. The cell membrane is often indistinct or absent. The peripheral cells are often palisaded, and glandular formation may be seen. These cells sometimes form nests or cords and have been described by Stout<sup>12</sup> as exhibiting "carelessly coiled festoons of ribbons." (Fig. I)

The stroma generally presents a rather characteristic appearance of hyperplastic connective tissue and some smooth muscle fibers. Some carcinoid tumors show a preponderance of one type of pattern, but the microscopic picture may vary with each individual lesion, so that some confusion among the investigators might be expected.



**Fig. 1.** High power magnification of lesion illustrating the "carelessly coiled festoons of ribbons" as described by Stout. The small epithelial cell with uniform round or oval nuclei is seen. (Photo by Dr. F. Porro-Pathologist St. Mary's Hospital, Evansville.)

ed. The argentaffin staining characteristic as described by Masson,<sup>6</sup> is not characteristic of all of the tumors. This is particularly true of carcinoids of the rectum, which often do not reduce silver salts. As was mentioned previously, Pop-off,<sup>9</sup> had the theory that the cells of the carcinoid tumor are in an exhausted state and, therefore, the argentaffin properties were transitory.

The diagnosis of a carcinoid is made by the finding of a hard small submucosal nodule, generally as an incidental finding to other pathology. The tumor, itself, is generally asymptomatic, although the patient may sometimes exhibit tenesmus similar to that manifested by a polyp. A carcinoid can present a picture similar to that of adenocarcinoma after it has attained a large enough size to ulcerate or become fungated. Following such a condition, it is not unusual for the carcinoid to manifest bleeding, and some change in bowel habit. With such a lesion, a biopsy is necessary to complete the differential diagnosis.

Tavenner<sup>13</sup> reported a case in which the pathologist had difficulty in differentiating the

carcinoid from a small celled scirrhous adenocarcinoma of the rectum. Jackman<sup>3</sup> reported a group of 87 rectal nodules of which four or 4.6% proved to be carcinoids.

The treatment is wide excision and removal of the entire nodule for biopsy purposes. If the nodule is larger than 2 cm., it must be suspected that there could be metastasis. If the lesion is large, ulcerative and fungating, a biopsy should be taken before any other procedure is attempted. The patient should always have complete studies for any possible metastasis, including barium enemas. The actual removal of the nodule generally does not entail much of a technical problem. The real heart of this problem would seem to be whether the lesion should be considered as benign or malignant.

Since it is generally agreed that there is no way to evaluate the degree of malignancy from the biopsy, the decision must then rest within the judgment of the examining surgeon. The decision then must be based primarily upon four things. 1.) The size of the lesion as to whether it is below 2 cm. or not. 2.) The appearance of the lesion, whether it might be ulcerative or fungating. 3.) The number of lesions. In other words, whether it is a solitary nodule or whether it is multiple, and 4.) Whether there are other signs of metastasis, such as might be manifested by x-ray, clinical symptoms, etc.

Certainly it is true that all carcinoids are neoplasms of potential malignancy. The average solitary small carcinoid can be safely removed by total excision and with careful follow-up of the patient, the surgeon should feel reasonably secure from metastasis. If a malignancy is suspected or demonstrated, then the patient should have a radical Miles resection.

### CASE REPORT

Patient, C. L. C.  
Hospital No. 215420

The patient was a white male, age 53, seen in the office February 4, 1954 with a complaint of pains in his back radiating down the course of the sciatic nerve in both legs. No bleeding was present. There was no history of constipation and no protrusion from the rectum. The patient was sent to this office as a referral from an internist who found a small submucosal nodule

in the anterior wall of the rectum as an incidental finding during a routine physical examination. The proctoscopic examination at the time he was seen in the office revealed a normal sized anal orifice. There was no external evidence of hemorrhoids. Digital examination confirmed the diagnosis of a palpable tumor in the anterior wall of the rectum. It was located at finger-tip height and was found to be slightly movable. The anoscopic examination revealed a small internal hemorrhoid, anteriorly. Nothing could be seen over the area of the nodule. The mucosa appeared normal. No color changes were noted. A sigmoidoscope was introduced to 25 cm. and no pathology encountered to that level.

The patient was admitted to Deaconess Hospital, Evansville, on March 8 and surgery was done the following day. The tumor was found to be a sessile type of lesion, submucosal in character. It was removed together with an internal hemorrhoid. The nodule when removed, measured approximately 0.5 by 0.5 by 1 cm. The mucosa was closed with continuous chronic 0 for hemastasis. The patient was returned to the room in good condition. His post-operative course was uneventful, and he was discharged on March 12, 1954.

Patient, C. L. C.  
Hospital No. 215420

### GROSS PATHOLOGY

The specimen consists of a piece of tissue measuring about 1.3 cm. in length. A part of it is covered by mucosa. Beneath this is a circumscribed nodular area measuring about 6 mm. in diameter which is quite firm in consistency and has a yellowish tinge.

### MICROSCOPIC PATHOLOGY

Sections of this tissue show a slightly flattened out colonic mucosa, lying on top of the glands and forming a somewhat indefinite oval structure in the submucosa although it extends out into the muscle tissue in a structure having a fibrous stroma. This structure makes up small strands of dark staining cells with dark nuclei and generally an indifferent cytoplasm

which is usually slightly darker in staining reaction. These strands are more or less regular lying in a dense fibrous stroma with the cells in equal and regular pattern. However, along the periphery are several nests of cells which take on a different type of structure. These cells appear more or less in an alveolar pattern with a circumscribed border around them. The cells have rounded, dark staining nuclei, the cytoplasm is granular and indefinite. Although the nuclei do not seem larger there is a much more abundant cytoplasm present here than elsewhere. Multiple small nests of these cells are seen along the periphery of the nodular process.

### DIAGNOSIS

Carcinoid of the rectum.

### SUMMARY

1. A case of carcinoid of the rectum is reported for statistical purposes.
2. A summary of the literature of carcinoids of the rectum is reviewed and four diagnostic criteria is presented.
3. Carcinoid tumors of the rectum are neoplasms of potential malignancy.
4. Carcinoid tumors of the rectum are probably for the most part slow growing.
5. All patients manifesting submucosal nodules should be urged to have them removed for biopsy purposes, even though they might be asymptomatic.

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# Gallstones and Pregnancy:

## REPORT OF A CASE AND REVIEW OF THE LITERATURE

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*R. J.*, A YOUNG, MARRIED woman, age eighteen, para I, gravida II, was first seen in the early morning of July 31, 1953. She was complaining of pain in the back in the region of the first and second lumbar vertebrae, accompanied by vomiting. The vomiting tended to relieve her pain. She had been having attacks of this type since the birth of her first child in August 1951. Food intolerance was denied. She had been treated previously elsewhere for "kidney infection." The attacks seemed to be increasingly severe with the progress of her present pregnancy. (When first seen she was entering the last trimester of her second pregnancy.)

The administration of morphine sulfate gr.  $\frac{1}{4}$  and atropine sulfate gr. 1/150 subcutaneously relieved her back pain. An x-ray of the lower dorsal and upper lumbar spine taken on August 3, 1953, showed no evidence of any lesion.

She was seen the second time on August 24, 1953, with symptoms practically identical with those seen on the first visit. This time a urinalysis showed a positive qualitative test for bile in the urine. For the first time attention was directed toward the biliary tract as the source of her attacks of colic. Morphine and atropine were again administered and she was placed on the hospital waiting list.

On August 27, 1953 she was admitted to St. Vincent's Hospital still complaining of back pain, vomiting, and passage of a small amount of urine. She localized her back pain in the region of the twelfth dorsal, first, second, and third lumbar vertebrae. Vomiting sometimes relieved the pain. Her urinary output had been depressed

for 48 hours. During the 24 hours prior to admission she had passed only 625 cc. of concentrated urine which was very dark in color and which showed a 3-plus test for sugar.

Her estimated date of confinement was October 22, 1953. Fetal movements were strong and fetal heart tones were good.

Her past history indicated that she had had eczema as a baby, and that she had been afflicted with repeated attacks of asthma since the age of 6. Many different drugs had been used for control, but the subcutaneous injections of  $\frac{1}{2}$  cc. of 1:1000 aqueous epinephrine, she stated, were all that could control her asthma. She administered this herself, while at home, when she felt she needed it.

Two operations had been performed on her nose, one in 1946, the other in 1950. Eczema involving the areola of the right breast had been present for two years.

The family history indicated her mother and father were living and well. (Her mother had had a cholecystectomy at the age of 25 after 7 years of intermittent gallbladder colic.) Two maternal aunts also had undergone cholecystectomy at relatively early ages. The patient's husband and daughter were in apparently good physical health. One brother had had eczema as a baby.

Physical examination revealed a well developed, well nourished white woman, age 18, who was pregnant. Her skin had a sallow appearance and there were areas resembling urticaria which she had been scratching and rubbing. These were located chiefly on the face and neck. The eyes reacted to light and accommodation,

and the extraocular muscles were intact. The sclerae showed a yellowish-green tint. The ears were negative. The mucous membranes of the nose and throat were injected. Polyps were present in both nasal passages. Her teeth were in good repair. There were no palpable nodes or abnormal pulsations noted in her neck.

Examination of the chest showed no enlargement of the heart, and no murmurs were heard. The rate and rhythm were normal. Blood pressure was 120/90. The lungs were clear to auscultation and percussion. The areola of the right breast was involved in three-fourths of its circumference by a weeping eczematous lesion.

The abdomen was protuberant. The uterine fundus extended 25 cm. from the pubis. The fetal heart tones were 144 per minute, heard best in the right lower quadrant. Striae were present across the lower abdomen. The liver, kidneys, and spleen were not palpable, and no tenderness was noted on palpation of the abdomen.

The extremities were negative; there was no edema and the reflexes were physiological. Examination of the back indicated no apparent external abnormalities in the lower dorsal or upper lumbar region. No tenderness was noted on palpation of the vertebrae; however, there was questionable tenderness in the right costovertebral angle with heavy percussion. Rectal examination showed the cervix to be long, firm, and closed.

The impression on admission to the hospital was an obstructive jaundice of unknown etiology, malignancy to be ruled out.

A complete blood count on admission showed a hemoglobin of 11.6 grams; R.B.C. 3,700,000; W.B.C. 10,550 with a differential of segmented neutrophils, 70; band cells, 11; lymphocytes 14; monocytes 2; and eosinophils 4; hematocrit of 38 and sedimentation rate corrected to 45 mm. per hour. Urinalysis on admission revealed a rust color, with a very cloudy appearance, an acid pH, and a specific gravity of 1.012. The urine was negative for albumin and sugar, there were 2 to 4 pus cells per high-power field with 1 red blood cell per high-power field. The urine showed presence of 4-plus amorphous crystals, and a positive qualitative test for bilirubin and urobilinogen with a trace of acetone.

The serum bilirubin on admission was 10 mgm %. The thymol turbidity was 3 units, which was normal. The cephalin flocculation

test showed a 2-plus reaction in 24 hours, and a 2-plus reaction in 48 hours. The Mazzini test was negative and the blood type was A-RhO positive.

On August 28 a second serum bilirubin was 8.45 mgm % with a Van den Bergh of 5.74 mgm % direct and 2.71 mgm % indirect. On August 31 the serum bilirubin was 7.6 mgm %.

A gallbladder series on August 31, 1953, revealed nonfunction.

Her course in the hospital was quite satisfactory. She was given codeine gr $\frac{1}{2}$  subcutaneously p.r.n. for pain. One liter of 5% glucose in saline was given I.V. on August 28. Epinephrine hydrochloride 1:1000 solution,  $\frac{1}{2}$ cc, was given p.r.n. to control asthma along with one Tedral® tab. q 4h. p.r.n. for asthma.

Consultation with an obstetrician was obtained and he agreed that since her jaundice and clinical condition were improving, there was no need to risk interruption of her pregnancy by performing gallbladder surgery. Her condition improved rapidly and she was discharged on September 2, 1953, on a fat-free diet.

The impression on discharge was jaundice, obstructive in type, probably secondary to stone or inflammation in the common duct. Malignancy had not been ruled out.

She was seen in the office on September 5, 1953, and had no complaints. On September 7, 9, and 11 she had attacks of biliary colic which required opiates for relief. On September 17, she was again seen in the office with no complaints. The fetus was all right. On October 3 and again October 5 she had attacks of biliary colic that required opiates for relief.

On the evening of October 5 she was again admitted to St. Vincent's Hospital with biliary colic. The serum bilirubin on admission this time was 2.93 mgm. %. The urinalysis was again positive for urobilinogen and bilirubin, and this time showed many pus cells and bacteria. She was started on Terramycin® 100 mgm. q4h. The complete blood count showed a hemoglobin of 12 grams; RBC 3,350,000; WBC 9,850 with differential of segmented neutrophils 57; band cells 17; lymphocytes 20; monocytes 3; eosinophils 3; and basophils 1.

Since she was within two weeks of term, and in view of her continued colic it was thought best to obtain consultation concerning induction of labor and termination of her pregnancy. On

October 6, 1953, her membranes ruptured and she began having irregular pains. Her pains were never marked and on October 7 they stopped altogether.

The obstetrical consultant advised the use of intravenous pitocin drip to initiate labor. Following a sterile vaginal examination to determine that the membranes were actually ruptured, pitocin drip was initiated. This was begun at 1:30 p.m. After administration of three minims intermittently over a period of 2 hours and 40 minutes, labor pains were established at an interval of every 3 minutes and each pain lasted 45 seconds. The drip was discontinued and labor progressed. At 9:55 p.m. she was delivered by means of low forceps and episiotomy of a living female infant, weight 6 pounds 10 ounces.

Delivery of the placenta was accompanied by profuse hemorrhage. Pitocin 1 ampule I.M. and ergotrate 1 cc. I.V. failed to stop bleeding.

Inspection of the cervix revealed no laceration. Manual examination of the interior of the uterus revealed no cause for the bleeding such as a retained placental cotyledon or uterine atony. The uterine cavity was packed with gauze, and the fundus was massaged continuously by the assistant while the episiotomy was being repaired. Five hundred cubic centimeters of whole blood were started on the patient. Her blood pressure reached a level of 80/45, 20 minutes after delivery. The uterine pack was removed after repair of the episiotomy (at 10:20) and bleeding had stopped. The estimated blood loss was 800 cc. One ampule of pitocin was added to the transfusion. The blood pressure gradually rose to a level of 108/70 at 2:00 a.m., 10-9-53. It remained at approximately this level until discharge on 10-11-53.

Against advice she scrubbed her floors and washed woodwork on the day after dismissal from the hospital. (This information was obtained from a talkative neighbor of the patient.) Bleeding did not recur.

On October 19, 30, 31, and on November 4 she was given opiate injections for the relief of biliary colic.

She was again admitted to the hospital on November 4. A repeat of the gallbladder series showed some dye in the gallbladder which outlined several non-opaque stones. A serum amylase showed 73 units. (Normal for this laboratory—25 to 65 units.)

On November 7, 1953 she was taken to surgery for cholecystectomy.

The surgical report follows:

Under general anesthesia a right subcostal incision was made exposing the gallbladder which was adhered to the omentum and duodenum from the fundus down to the cystic duct. The omentum was freed down to the cystic duct and the pouch along with the cystic duct was found packed full of stones and fine gravel.

It was with extreme difficulty that this cystic duct fascia could be dissected free from the common bile duct and hepatic vessels, because the cystic duct was parallel and adjacent to these structures. However, it was freed of stones which were milked up into the gallbladder, after which the common duct was palpated and checked thoroughly and there was no evidence of stones in the common duct.

The cystic duct was then ligated and the gallbladder was removed from above downward in order to avoid damage to the hepatic vessels and common duct. The gallbladder was removed and the raw surface was closed with interrupted No. 00 sutures. One small Penrose drain was inserted into the foramen of Winslow and was brought out through the wound.

The pancreas was slightly enlarged and firm but not nodular. The liver, stomach, duodenum, kidneys, and spleen were normal to palpation. The omentum was tucked around the lower liver bed, after which the abdomen was closed in layers.

The peritoneum and transversalis were closed with chromic No. 0, fascia with chromic No. 0 interrupted, skin with black silk.

Patient was in good condition at close of surgery.

Pathological report:

Tissue submitted:

Gall Bladder.

Pre-operative Diagnosis:

Cholecystitis with cholelithiasis.

Specimen consists of a gallbladder which measures 7 cm. in length, varies in X-diameter from 1 to 2½ cm. It is partially covered by serosa which is yellow-stained, wrinkled, appears fairly smooth. The hepatic surface is irregular with many chocolate colored areas of hemorrhage. Cross-section reveals the wall to measure 2 mm. in thickness. The mucosa is finely



granular and light brown in color. There is contained in the lumen of the specimen approximately 6 small green multifaceted soft stones.

Sections: 1 piece.

Microscopic: Sections of the gallbladder show the mucosa to be thrown into villous folds. The villi are broadened. There are infiltrates of lymphocytes in the muscularis and submucosa. In one portion of the section there is a rather heavy paravascular accumulation of lymphocytes and eosinophils.

Diagnosis: 1. Chronic cholecystitis

2. Cholelithiasis

Her postoperative course was somewhat stormy since on the second postoperative day she developed an asthma attack which would not yield to somewhat heroic doses of adrenaline—as much as 0.5 to 1 cc.—1:1000 solution every 20 minutes. She also developed a fever which reached a high of 102° on the fourth postoperative day. It was apparently secondary to bronchial infection. Terramycin® 100 mgm. every 4 hours controlled this infection. She was discharged on the seventh postoperative day following removal of surgical sutures.

*Comment:* This case presented several problems:

The first and most important problem for consideration was the effect which jaundice might have on the fetus. Fortunately the obstruction was not complete and the icterus never reached extremely high levels. Had the obstruction been complete and persistent, I am sure the conservative treatment which we followed would have been precluded. Whether cholecystectomy would have initiated labor is a question which, happily, cannot be answered in this particular case. The possibility of premature labor under such circumstances is a most effective deterrent to overzealous and premature surgical intervention.

(I have been unable to find anything in the literature concerning the effect of jaundice during pregnancy upon the unborn fetus.)

The second problem presenting itself was the uterine inertia following spontaneous rupture of the membranes. Pitocin drip remedied this situation quite well. The immediate postpartum hemorrhage is difficult to explain. One could hypothesize that the persistent low-grade jaun-

dice had resulted in alteration of the clotting mechanism to some degree, but this is strictly in the realm of speculation. We did not have a bleeding, or clotting, or prothrombin time done. Probably we should have.

The next situation presenting itself was the very real danger of addiction in this young woman. She was having frequent attacks of pain; there can be no doubt of that, and the pain could be controlled only by the use of opiates. Codeine, demerol and scopolamine, by hypodermic and A.S.A. compound with codeine by mouth were all ineffective in controlling her pain. Morphine or pantopon afforded relief very well, but during the month before her last admission the effectiveness of these two drugs became noticeably less. Had we waited three months following delivery before undertaking surgery, as we had originally planned, we might have been presented with an addicted patient.

Several aspects of the case deserve further comment. The age of the patient, which was at first considered rather unusual, we find upon searching the literature is not so unusual after all. Gerwig and Thistlethwaite have reported 10 cases of biliary colic occurring in women between the ages of 20 and 30 and all of these cases began having trouble either during pregnancy or shortly after delivery.<sup>12</sup>

Biskind and Peviaroff reported 612 cases of cholelithiasis in women at the Mt. Sinai Hospital in Cleveland who were operated upon between the years 1916 to 1938 inclusive. One hundred and ten of these were between the ages of 16 and 30 and 474 were within the limits of the child-bearing age.<sup>3</sup>

Another aspect of the case that deserves mention is the atypical pain which she experienced. The pain always began in her back. In fact the location of the pain led one examiner to the conclusion that it originated primarily from the kidneys. Early in the course of her illness she localized her pain in the region of the second lumbar vertebra. X-rays of this portion of the spine were normal. It was not until the discovery of bile in her urine by means of the qualitative office test that the real nature of her illness was suspected. Three days later on admission to the hospital for the first time, clinical jaundice was quite evident. The oliguria could be explained on the basis of rather persistent vomiting during the time the 24-hour specimen was being col-

lected. At no time did she complain of food intolerance.

One might argue that her back pain was the result of pancreatitis and this cannot be refuted entirely; however, the one serum amylase which we obtained, we felt, was not significantly elevated and the pancreas at the time of surgery did not appear to be the site of this pathologic process.

The family history of cholelithiasis may be of significance. Her mother had a cholecystectomy at age 25 and two maternal aunts also had cholecystectomies during their thirties. It will be interesting to note whether this young woman's daughters have a tendency to develop cholelithiasis at an early age.

It should be noted that the cause for gallstone formation has never been determined. There are some facts, some statistics, and some ideas available in the literature.

Many years ago typhoid fever was thought to be the initiating factor in the formation of gallstones. Now that the incidence of typhoid fever has been greatly reduced, there has been no corresponding decrease in the incidence of gallstones. This theory, therefore, has lost favor.

It has been pointed out by many investigators that the ratio of cholelithiasis in men and in women is approximately one to four. It has also been pointed out by many authors that gallstones are approximately 10 times more frequent in women who have borne children than in those who have not.<sup>1, 6, 17</sup> I am not sure what this latter statement proves except perhaps that the percentage of women who bear children is much greater than those who do not. (A check of my office records shows that of the first 40 records encountered of women past the age of 25, 35 of them had been or were married and of these, 32 had borne at least one child.) To affix an undue amount of emphasis upon child-bearing as an etiological agent in gallstone formation, indeed, tends to place the male of the species who has cholelithiasis in a rather peculiar position.

One must, I think, look elsewhere. The gallbladder functions as an organ for the storage and *concentration* of bile from the liver.<sup>2, 5</sup> Any condition in the body that might tend to cause this physiological process of concentration to be

carried to extremes and would be conducive to gallstone formation.<sup>5</sup>

A temporary but rather prolonged spasm of the sphincter of Oddi or a temporary, mild inflammation in the common bile duct producing some degree of obstruction to the outflow of bile could allow enough fluid to be reabsorbed through the gallbladder mucosa to result in the precipitation of some of the biliary constituents—usually cholesterol or bile pigments. Once started, the process could continue under conditions approaching normal physiology.

But why should the process begin during pregnancy?

Blood cholesterol increases during normal pregnancy.<sup>5, 10, 16</sup> The maximum level is usually reached at about the thirtieth week—the average increase in free cholesterol at that time is 25 per cent and the increase in the ester cholesterol is about 9 per cent. The two cholesterol fractions gradually become about equal in concentration in the later weeks of pregnancy, and this is brought about by a diminution in the concentration of the free portion with an elevation of the esterified portion until each is approximately 12½ per cent above normal at the time of parturition. Potter in his work on bile taken from gallbladders at the time of cesarian section was unable to demonstrate any definite ratio between blood cholesterol and bile cholesterol concentrations at term.<sup>18, 20</sup>

Gerdes and Boyden in their cholecystographic studies on 21 healthy gravid women found that the rate of emptying of the gallbladder—as tested by the modified Boyden meal—is not altered greatly during the first three months of pregnancy, but during the second and third trimesters there is a definite retardation of the flow of bile as compared with non-gravid individuals.<sup>11</sup>

The comparison of the rate of emptying of the gallbladder in the same individual before and after parturition was quite significant. In five patients subjected to this test the mean discharge at 40 minutes after eating was 38 per cent during pregnancy and 71 per cent 6 to 7 weeks postpartum.

The results of Westphal's peptone and pilocarpine experiments with gravid women indicated that the initial delay in response to a motor meal is due to a hypertonic condition of the sphincter choledochus. In other words the delay



is attributed to a physiological dyskinesia reflecting the changed hormonal content of the organism during pregnancy. One cannot refute the existence of such a "changed hormonal content," but neither can one define exactly what it is or how it is changed.

It is known that estrogenic hormone gradually increases in concentration until it reaches a peak at about the tenth lunar month, at the time of the onset of labor.<sup>8</sup> Could this hormone, i.e. estrogen, act as an antagonist to the action of the hormone stimulating gallbladder emptying—namely cholecystokinin? No one knows, but perhaps experimental work, yet undone, will throw some light on this question. It doesn't seem likely that chorionic gonadotrophin could act to neutralize cholecystokinin, since chorionic gonadotrophin reaches its peak during the second month of pregnancy. According to Gerdes and Boyden, the gallbladder dyskinesia occurs during the last two trimesters of pregnancy. This would throw suspicion on the estrogenic hormone rather than chorionic gonadotrophin, or progesterone if one is to accept the "changed hormonal content" of biliary dyskinesia during pregnancy.

Riddle's experimental work on birds indicates that the blood lipids, including cholesterol, increase in female birds during puberty and the period of egg production, and the same thing can be produced by the administration of estrogens to male and non-laying female birds.<sup>19</sup>

The ratio of cholesterol and the bile salts in gallbladder bile changes during the latter months of pregnancy; a change marked by a decrease in the concentration of the bile salts with an increase in the concentration of cholesterol.<sup>20</sup>

This changed ratio, it has been pointed out, is similar to that found in gallbladders with damaged walls. It is probably a precursor of the formation of gallbladder calculi.

All these facts and theories are interesting but do not explain the formation of gallstones in the male—nor for that matter are they completely satisfactory explanations for the formations of calculi in the female. Many instances of gallstone formation in spinsters and in married but childless women are on record.

Two other theories concerning the formation of gallstones should be mentioned. Alkalinity of the bile collected in the gallbladder has been

cited as a possible factor in the formation of gallstones since one of the functions of the gallbladder apparently is to acidify the bile collected therein.<sup>2</sup> Exactly how this acidification takes place has not been explained, but it does occur. It would seem that there must be the additional factor of stasis present, else the formation of stones within the biliary and common ducts—the bile of which is normally alkaline—would be much more frequent in cases having undergone cholecystectomy.

With continued alkalinity of the bile within the gallbladder, calcium carbonate could be precipitated and could serve as a nidus upon which the other biliary constituents could be deposited.<sup>2</sup> (If this is true, the central portions of gallstones should contain a higher content of calcium than the remainder of the stones.)

Still another theory has been propounded recently by Hartmann of the University Clinic at Göttingen, Germany.<sup>15</sup> A summary of his work follows: "Since cholesterol and proteins occur together in bile, a possible deleterious effect of the latter on the colloidal state of the former may be considered in connection with concretions. In cases of disease of the liver and gallbladder, followed by gallstones, a decrease of albumin and increase of globulin in the secretion has frequently been reported. A sol was made by diluting a saturated solution of cholesterol in methanol with saline. Solutions of human albumin, human globulin, human fibrinogen, or egg albumen were added to this sol. After 40 hours the cholesterol sol flocculates spontaneously. Addition of albumin prevents flocculation (protective colloid action). The other proteins promoted precipitation in the order globulin < egg albumen < fibrinogen. The stability of pure sol is slight.

"The highly negatively-charged albumin molecules adhere to the cholesterol surfaces together with their water of solvation. This system resembles milk. The neutralization of charge disturbs the stability of cholesterol, and flocculation ensues.

"Fibrinogen with its high content of the basic groups of serine, and the basic egg albumen, act particularly in this manner. Probably, in normal bile, cholesterol is protected by albumin against flocculation. Decrease of albumin content in cases of parenchymatous lesions of the liver or



increase of globulin and fibrinogen, e.g. owing to inflammation of the gallbladder, causes flocculation of cholesterol and thereby concretion."

One can assume from the multiplicity of theories regarding the formation of gallstones that the actual cause really isn't known. The profusion of explanations only serves to convince one that all is yet confusion.

Such discussion has led us pretty far afield, and we should get back to the case at hand. Was there any relationship between the calculus formation in this patient and her asthma and eczema? None seems apparent. Personal experience has never indicated any relationship, and a search of the literature with this specific point in mind failed to unearth any evidence along this line. Probably the coexistence in this case was coincidental.

The various complications of cholelithiasis, which now seem rather remote in this particular case, were, nevertheless, a source of constant worry and apprehension not for the patient but rather for the physician. The thought of the possibility of an empyema of the gallbladder with rupture into the peritoneal cavity isn't always conducive to restful slumber for the physician. The knowledge that two lives would be endangered by such a catastrophe seems to more than double the amount of anxiety which the physician is forced to suppress.

Admittedly, this is a rare occurrence from a statistical standpoint; yet it does happen, and when it does, statistics seem to be the least important thing to consider.<sup>9, 14</sup>

Complete obstruction of the common duct has been mentioned as a possible complication.<sup>4, 13</sup> A stone in the ampulla of Vater with complete obstruction and a concomitant pancreatitis would not be an easy situation to handle, especially with a pregnant uterus obscuring the operative field.

Erosion of a stone through the gallbladder wall and through the wall of the duodenum, ileum, or colon is a possibility not to be forgotten.<sup>22</sup> Indeed this is a rare complication, but its rarity doesn't make it any easier to handle when it does occur. In the case presented, we can be thankful that most of our fears were unfounded, and that the conclusion of the case was ultimately satisfactory to the patient, to her child, and to her doctors.

*Conclusions:* No conclusions can be drawn from a single case. A search of the literature

reveals that the cause for gallstone formation is not known. Cholelithiasis occurs more frequently in women than in men, in a ratio of about four to one. Some authorities feel that the changes incidental to pregnancy are responsible in large part for the formation of stones in the female. Some attempts at explanation, gleaned from the literature, are presented. None is entirely satisfactory.

### Summary

A case of cholelithiasis complicated by pregnancy in a young woman is presented in detail. A short review of the literature is included, and some questions are asked and left unanswered.

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### An Abstract:

### POISONINGS

The authors, both members of the Kansas State Board of Health, review thoroughly the problems raised by the newer pesticides. They identify very many of these poisons by their trade and chemical names and find that most of those now in use fall into the class of the chlorinated hydrocarbons or the organic phosphates. The former, of which DDT is a very common member, may enter the body through skin, gastrointestinal or the respiratory systems. Their physiological action is that of a cerebral stimulant resulting in hyper-excitability, irritability, sometimes convulsions or loss of equilibrium. Treatment is by decontamination of the skin with soap and water avoiding oil solvents, emptying the alimentary tract by lavage and saline laxatives, and heavy sedation.

The organic phosphates represented by Parathion or OMPA are more of agricultural than of domestic-garden use. They may enter the body by any of the routes previously mentioned, though most commonly poisoning has been the result of contamination of the skin with a concentrated chemical or that plus inhalation of the spray. The action of the organic phosphates is to inhibit cholinesterase allowing acetylcholine to accumulate. Symptoms are multiple, including headache, giddiness, blurred vision, nausea, cramps, diarrhea, sweating, salivation, pulmonary edema, convulsions, loss of reflexes and coma. Treatment is to keep the patient completely atropinized which may require from 1 to 2 mg. an hour at the beginning. Oxygen, and especially oxygen under positive pressure, is valuable here. Artificial respiration is frequently needed and the acute emergency may last as much as 48 hours.

The authors make the point that the solvents for these drugs such as kerosene, toluene or xylene themselves may be very toxic and fatal poisoning may follow aspiration of small amounts leading to severe drowsiness and in some cases to broncho-pneumonia. Here again lavage and saline laxatives are advised.

A last major type of poisoning occurs from drugs of the Warfarin type which exert dicumerol action following ingestion. Treatment here is with blood transfusions and vitamin K until the prothrombin time is maintained normally.

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Hood, Thomas R., M.D. and Wright, Evan, M.D.: Poisonings with the Newer Pesticide Compounds. *J.M. Soc. Kansas.* 384:387. Vol. LV, No. 7, July, 1954.

# Unusual Case Report:

## COARCTATION OF THE AORTA, CONSTRICTIVE PERICARDITIS AND PLEURITIS, AND PRIMARY CARCINOMA OF THE LIVER OCCURRING IN ONE PERSON\*

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**C**OARCTATION OF THE AORTA, constrictive pericarditis and pleuritis and primary carcinoma of the liver are all relatively rare diseases but to have all of these diseases occur in one person is certainly infrequent. Whether or not coarctation of the aorta predisposes to the occurrence of constrictive pericarditis and pleuritis is not known. It is known, however, that cirrhosis of the liver predisposes to the development of primary carcinoma of the liver. In the case to be presented here hepatomegaly as a sequence of chronic cardiac failure from constrictive pericarditis had been present for many years prior to the development of the primary carcinoma of the liver.

### CASE REPORT: CASE NO. 5014

#### *First Hospital Admission:*

The patient, a 21 year old white male was admitted to The Ingham Sanatorium February 19, 1952, with the chief complaint "Shortness of Breath". Present illness: He stated that he had been short of breath as long as he could remember. The abdomen had been distended since childhood. In 1944, at the age of 13 years, he had measles following which the dyspnea became progressively worse and the ankles began to swell. The dyspnea and edema have gradually become worse since that time, causing him to be confined to bed. Prior to admission here he was hospitalized for nine weeks in another hospital; prior to that he had been hospitalized in several other hospitals. He is known to have had hypertension since 1944, recently the urine has shown 4+ albumin.

Past history: Reported to have had pneu-

monia in 1949 at which time hemoptysis occurred. No known childhood disease other than measles. Tonsillectomy and adenoidectomy had been performed. He has had palpitation, edema, and "asthma" for years. A brother and sister are said to have heart murmurs.

#### *Physical Examination:*

The patient is a well developed, intelligent, mentally alert white male who appears to be in good spirits. Generalized edema is present with marked pitting edema of the ankles; the edema diminishes progressively from the lower to the upper parts of the body. The lungs present fine respiratory rales at the bases. The heart was enlarged to the left anterior axillary line. A low systolic murmur was heard in the right and left anterior 2nd intercostal spaces.

B.P.: Right arm 180/115 mm. Hg.; left arm 190/115 mm. Hg. Left thigh 150/130 mm. Hg. The femoral, dorsalis pedis and posterior tibial pulses were markedly diminished. The abdomen is protuberant. Shifting dullness was indicative of ascites. The liver is markedly enlarged to a hand's breadth below the right subcostal margin; it is also tender.

#### *Laboratory Reports:*

Urinalysis on 2-22-52 showed 4+ albumin; blood count was normal. Chest x-ray studies on 2-20-52 and 2-22-52 revealed increased vascularity of the pulmonary fields, bilateral pleuritis, and cardiac enlargement. E.K.G. interpreted as showing right ventricular preponderance with right bundle branch block.



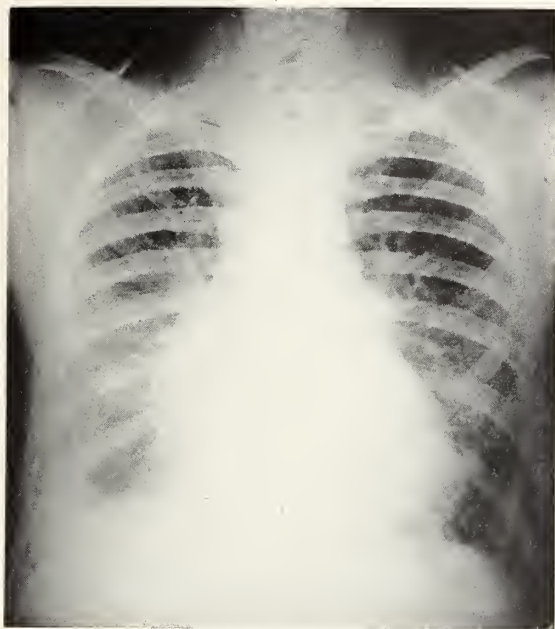


Fig. 1. CASE NO. 5014

Chest film, anterior-posterior view taken 2-22-52 prior to operation. There is evidence of bilateral chronic pleuritis and marked enlargement of the heart. Some calcification of the pericardium can be seen.



Fig. 2. CASE NO. 5014

Chest film, lateral view, taken 2-22-52. The calcification in the pericardium is evident on this film.

#### *First Operation:*

On 2-28-52 with the patient in the lateral position, under nitrous oxide, oxygen and ether anesthesia administered through an endotracheal tube exploratory thoracotomy of the left pleural cavity was carried out. Operation began at 8:22 A.M., ended at 11:40 A.M.

Through a postero-lateral skin incision a long segment of the left 4th rib was resected subperiosteally. The intercostal vessels were noted to be dilated. The visceral and parietal pleura were densely adherent throughout, being most dense over the mediastinal surface. After the upper lobe had been freed a dense layer of scar tissue was found overlying the entire mediastinum. Scar tissue approximately  $\frac{1}{4}$  inch in thickness covered the aorta. The pericardium was markedly thickened and calcified. The scar tissue over the arch of the aorta was incised and the dissection carried to the left common carotid artery. As the dissection was carried along the descending aorta the coarctation of the aorta was found about  $2\frac{1}{2}$  inches distal to the ligamentum arteriosum. The mobilization of the aorta was extremely difficult due to the dense fibrosis. A small aneurysm of the 1st left intercostal artery was noted. As the operation progressed the

patient's condition deteriorated as pulmonary edema supervened. Accordingly the operation was terminated. The left pleural cavity was drained through a long multiple hole rubber tube with closed underwater drainage plus added suction.

#### *Post Operative Course:*

Penicillin was continued. The patient was maintained on digitalis and low salt diet. His condition improved very little.

#### *Second Operation:*

Operation began at 1:05 P.M., ended 5:40 P.M., 3-11-52. With the patient in the lateral chest position under endotracheal nitrous oxide, oxygen and ether anesthesia the scar of the previous thoracotomy incision was excised. The left pleural cavity was entered and the adherent left lung was freed. The entire lung was decorticated on all of its surfaces. The diaphragm was freed in the costophrenic angle. The entire pericardium was thickened, up to  $\frac{1}{4}$  inch and was calcified throughout. This thickened and calcified pericardium was markedly adherent to the heart muscle. The entire pericardium from the base of the heart to the diaphragm

and from the pulmonary vein on the left to the phrenic nerve on the right was resected. At times during this procedure cardiac irregularities developed. The surface of the heart was sprayed with 5% novocaine and novocaine was given intravenously. As the decortication of the heart proceeded, the heart beat became stronger until at the end of the procedure the rhythm of the heart was quite strong and regular. After the heart had been liberated attention was directed to the coarctation of the aorta. The aorta above and below the coarctation was mobilized. However, due to the density of the scar tissue and the obvious difficulty associated with any attempt to approximate the ends of the aorta after the stenosed part had been resected and the patient's general condition which had deteriorated during the long operation period, the operation was terminated. The chest cavity was drained as noted after the first operation.

#### *Post Operative Course:*

Following this operation the patient improved rapidly. The edema and dyspnea subsided. He lost 15 pounds of edema fluid. For the first time in many years he could get around without difficulty. The blood pressure remained elevated. A third operation, for the coarctation of the aorta was contemplated but the patient felt so much better that he decided to postpone the operation and was discharged home on 3-29-52.

#### *Post Hospital Course:*

He was seen at regular intervals. His improvement was remarkable. The patient felt well and had no complaints and worked full time. The blood pressure remained elevated to 240/110 mm. Hg. The liver remained enlarged. In May, 1953, he was hospitalized elsewhere for six days because of jaundice; he was told that he had a virus infection of the liver.

On 6-12-53 during a routine examination, the patient stated that he had felt a mass in the abdomen. Examination revealed a mass in the upper mid-epigastrium. A tumor of the liver was suspected and operation was advised. The patient was enjoying his new life so well that he was reluctant to submit to another operation.

#### *Second Hospitalization:*

Admitted 10-12-53: Discharged 11-2-53:

The patient had no complaints. A large hard

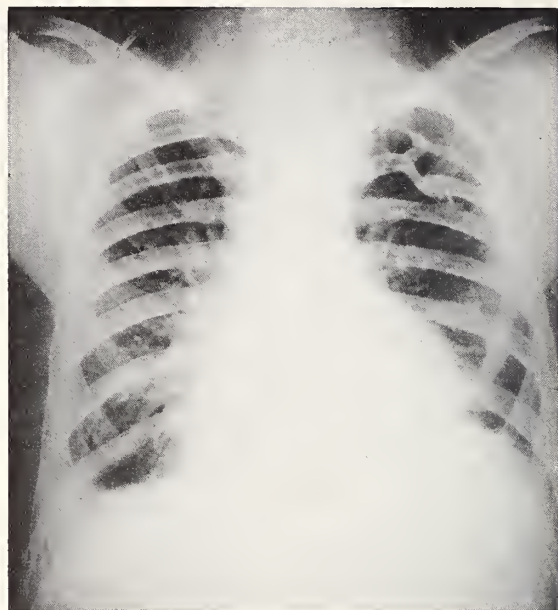


Fig. 3. CASE NO. 5014

Chest film, anterior-posterior view taken 10-13-53. Decortication of the heart had been performed on 3-11-52. This operation had allowed this 22 year old man to become active and engage in full employment for the first time in his life. His hypertension remained, however, as the coarctation of the aorta was still present.

mass was felt in the upper mid-epigastrium; this mass was felt to be in the liver, probably the left lobe. The liver was enlarged a hand's breadth below the right subcostal margin. The B.P. in the upper extremities was 220/110 mm. Hg. No other pathology was noted.

On 10-14-53 exploratory laparotomy was carried out.

At operation a large tumor was found involving the left lobe of the liver and extending into the right lobe of the liver. Metastases to the pelvic node were found. The pathologist reported that the tumor was a primary carcinoma of the liver with metastases to the pelvic nodes.

#### *Summary:*

A case report of constrictive pericarditis and pleuritis, coarctation of the aorta and primary carcinoma of the liver occurring in one unfortunate young man is presented. The patient had been in chronic cardiac failure with marked hepatomegaly for many years prior to the development of the carcinoma of the liver. The cardiac failure was relieved by pericardiectomy. Remarkable clinical improvement followed. Excision of the coarctation of the aorta was con-

templated. Primary carcinoma of the liver supervened.

The question, as to the part chronic passive congestion and cirrhosis of the liver may play in the development of primary carcinoma of the liver, is raised.

Another interesting feature of this case is that while a definite coarctation of the aorta existed as proved at operation and reflected in the high blood pressure in the upper extremities, hypotension in the lower extremities was not marked; further, femoral pulsations could be palpated.

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*An Abstract:*

## MANAGEMENT OF BURNS

The management of burns presents a very common problem for both the general practitioner and the surgeon, because of the expansion of industry, transportation dependent on inflammable hydrocarbons, and the use of inflammable solvents in the home.

Burns are usually described according to the textbook grouping of first, second and third degree. While the grading of the burn is not immediately necessary, the estimation of the burned surface is essential. Deep burns of 50 per cent or more of the skin surface are considered hopeless. The extent of the burn is also a guide as to the amount of plasma, fluids and electrolytes the patient should receive.

Many surgeons believe that shock does not develop immediately, and that shock is not as hazardous as formerly supposed, and the burn should be dressed first and the shock treated later. This author does not concur with this idea and advises the immediate treatment of shock in all cases where the extent of the burn is over 15 per cent.

Blood transfusion is not recommended until the hemo-concentration has been corrected. The amount of plasma fluids or blood needed is variable and difficult to determine. A suggested rule for the first twenty-four hours is: the body weight in kilograms multiplied by the percentage of surface burned equalling the cubic centimeters of each plasma or dextran, and also equal to cubic centimeters of electrolyte required. Usually after the second day, the patient can take adequate amounts of fluids and electrolytes by mouth. Dextran offers promise of being an adequate substitute for plasma.

Stimulants are not helpful and morphine should be given sparingly. After treatment for shock is well established, treatment of the burn wound itself is instituted. General anesthesia is definitely contraindicated, and asepsis is to be rigidly maintained. Tetanus antitoxin or toxoid should be routinely given, and anti-gas-bacillus serum should be given if the burn is near the rectum. For the first eight to ten days 300,000 units of penicillin should be given daily. The burned area is cleansed with bland soap. Blebs are opened. Tannic acid once popular is not used because of the severe liver damage it may produce. A host of ointments and dressings have been recommended, but none seems to be superior to simple vaseline gauze. Frequent dressings are considered to be a source of infection. The dressings are removed in ten to eighteen days, and compresses are applied until the slough is complete and the wound is ready for grafting.



# The Urologist and Hypertension

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ACCORDING TO WAKERLIN about 15,000,000 people in the United States are hypertensive. Of these, 95 per cent are of the so-called essential type. The other 5 per cent of the cases are caused by definite known pathological entities. Wakerlin classifies these known pathological conditions as follows:

- A. Renal; such as atrophic pyelonephritis, glomerulonephritis, hydronephrosis, tuberculosis, etc.
- B. Cerebral or neurogenic; such as increased intracranial pressure from trauma, tumor, or inflammation, and lesions of the diencephalon or brain stem.
- C. Cardiovascular; such as congenital anomalies of the heart or great vessels, and certain cardiac diseases.
- D. Endocrine; such as pituitary basophilism, adrenocortical tumors, and pheochromocytomas.

Just what fraction of the 5 per cent known causes of hypertension is caused by kidney and adrenal disease is difficult to estimate. Puppel and Alyea state that 2 per cent of essential hypertensive patients have a surgical renal disease. This does not mean, however, that the coexisting renal disease is responsible for the hypertension in all 2 per cent of the cases. No attempt will be made to discuss the various theories of the renal cause of hypertension. Suffice it to say that much has been done on this problem, is still being done, and that it has been definitely proven that conditions affecting one

or both kidneys adversely can cause hypertension.

## Bilateral Renal Conditions Causing Hypertension

All physicians are familiar with the hypertension caused by medical conditions which affect both kidneys such as glomerulonephritis, chronic pyelonephritis and polycystic disease. The hypertension in these cases is not amenable to direct surgical attack on the kidneys. Every urologist has had the experience of seeing the blood pressure in hypertensive patients with bilateral hydronephrosis from bladder neck obstruction fall appreciably and remain down following prostatectomy. After prostatic hyperplasia, cancer of the prostate, urethral stricture, and median bar are the most common of the infravesical causes of bilateral hydronephrosis. Other surgical conditions affecting both kidneys are bilateral ureteropelvic junction strictures, bilateral ureteroceles, and bilateral staghorn calculi. That the blood pressure falls in hypertension associated with some of these cases after surgery is interesting, but of secondary importance, because the urologic condition itself warrants surgery.

## Unilateral Renal Conditions Causing Hypertension

It has been since Goldblatt's classical work of producing hypertension in dogs, by partially occluding a renal artery with resulting ischemia of one kidney, that attention has been focused on unilateral renal disease as a surgically curable cause of hypertension.

Early, unilateral renal disease, as a surgically curable cause of hypertension in humans, fell into disrepute because it was discovered that

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hypertension had recurred in many of the cases reported as cured. Once it was established that to be classed as a cure a case must be followed at least two, and preferably five years, clear cut cases of cure appeared, that established beyond doubt, the value of nephrectomy in unilateral kidney diseases associated with hypertension. Some of the most recent authors reporting interesting cases are Hoffman, Bailey and Fort; Owen, Jr. and Pearlman; Wayman and Ferris; and Puppel and Alyea. Braasch reports 100 cases who presented themselves for treatment of hypertension and in whom unilateral renal abnormality was found. A two year follow-up after nephrectomy disclosed that the blood pressure had returned to normal, or been appreciably reduced, in 64 per cent of the cases.

Out of the confusion of the many papers discussing this problem both pro and con, it is possible to draw some conclusions.

Hypertension can be caused by disease in one kidney. This disease may be hypoplasia, atrophy, infected hydronephrosis, infarction, obstruction of the renal pedicle, and other conditions. In other words, it is possible for practically any pathologic process in a kidney to produce hypertension. When this diseased kidney is removed in the presence of hypertension, the blood pressure may return to normal, or be reduced, in about 50 per cent of the cases.

There is no way to determine preoperatively which cases will definitely benefit. Braasch states that atrophic pyelonephritis, hydronephrosis with infection, and tuberculosis, are the three renal lesions, removal of which will yield the best results.

Wayman and Ferris suggest that a lack of depressor effect with an autonomic blocking agent, as tetraethyl ammonium chloride, indicates that a favorable response may be obtained.

In general it can be stated that nephrectomy should be performed in hypertensives for the same urologic principles as in normotensives. The contraindications to nephrectomy in hypertension are about the same as in normotension; i.e., azotemia, severe cardiovascular disease, absence of a normal kidney on the opposite side, a recent cerebral accident. The best results in lowering the blood pressure are obtained in children or young adults. Over the age of 50, good results are less frequent.

The problem is in making an early diagnosis of renal disease in hypertension. Every case of hypertension with associated urinary findings such as pus, red cells, or albumin, or suggestive urinary tract symptoms should be investigated thoroughly to include pyelograms, either intravenous or retrograde. In individuals under the age of 50, or in those who have had a recent onset of hypertension or hypertensive symptoms, pyelography is indicated in the absence of urinary symptoms or findings, as a silent unilateral renal lesion may be present, such as hypoplasia, atrophy, hydronephrosis, or cyst. Renal infarction should be suspected in hypertension developing after trauma to a kidney.

It is obvious that many negative pyelograms will be performed if these precepts are followed, but it is only in this way that all cases of hypertension, due to unilateral renal disease, will be discovered and cured by nephrectomy.

### Adrenal Causes of Hypertension

Of the adrenal causes of surgically curable hypertension, pheochromocytoma is the most important. Hypertension is often seen in hyperplasia of the adrenal cortex or functioning cortical tumor, benign or malignant. This hypertension is, however, only a part of the whole complex picture of the so-called Cushing's syndrome and should occasion no difficulty in recognizing the source of the hypertension.

Pheochromocytoma, on the other hand, often presents great difficulty in diagnosis. This is a tumor, benign or malignant, composed of chromaffin cells derived from the sympathetic nervous system and usually found in the adrenal medulla. These tumors may, however, be found anywhere along the sympathetic chain from neck to pelvis. Pheochromocytomas elaborate vasopressor substances which produce hypertension. Originally, it was thought that the hypertension caused by these tumors was periodic with exacerbations and remissions. It is now definitely realized that pheochromocytomas can cause a steady prolonged hypertension resembling that of the essential type. Because of this, almost all, if not all, hypertensives should be subjected to at least one of the various screening tests for pheochromocytomas.

One of the easiest is the Regitine test and is performed as follows. The test depends on the adrenergic block by Regitine of the pressor ef-

fects of epinephrine and/or nor-epinephrine secreted by the pheochromocytoma. The use of sedatives, narcotics, or other antihypertensive drugs for two days before the test should be avoided. Uremia is a contraindication. Determination of the basal blood pressure must be made by having the patient rest in a supine position until the blood pressure is stabilized. The pressor response to the needle should be allowed to fall before the Regitine is injected. Adults receive 5 mgms. of Regitine methanesulfonate, either intramuscularly or intravenously. In children 3 mgms. intramuscularly or 1 mg. intravenously is usually considered adequate. The maximal depressor effect is usually obtained within 20 minutes after intramuscular injection and within two minutes following intravenous injection. The blood pressure slowly returns to normal in three to four hours after intramuscular injection and in 10 to 15 minutes (occasionally  $2\frac{1}{2}$  minutes) after intravenous injection. The response may be considered positive if the fall in pressure exceeds 35mm. Hg. systolic and 25mm. Hg. diastolic. If the test is positive, confirmation should be sought with repeat and other diagnostic tests. False negatives may be obtained if, at the time of the test, the tumor is not discharging vasopressor substance into the blood stream. In coexistent essential hypertension and pheochromocytoma with sustained hypertension the fall in blood pressure may not be marked. If pheochromocytoma is suspected the Regitine test should be repeated by the intravenous route. It would appear that the intravenous Regitine test, because of its speed, would be more practical for the busy practitioner.

Patients who have definite periodic attacks of hypertension and hypertensive symptoms such as headache and dizziness should be subjected to several of the tests for pheochromocytoma. Among these are the histamine and piperoxan tests. One negative response should never be taken as conclusive in periodic hypertension.

If pheochromocytoma is suspected, retroperitoneal air injection may be done in an attempt to visualize the tumor roentgenographically. Both sides of the abdomen may be visualized by one insufflation in the retrorectal space. Surgical approach is best carried out through a transverse upper abdominal incision, especially if pheochromocytoma is suspected without the location known, permitting exploration of both adrenals

and, if necessary, both sympathetic chains. About 10 per cent of pheochromocytomas are bilateral.

Great care must be taken in handling of the tumor and it is essential to ligate the blood supply early. Manipulation of a pheochromocytoma may express great amounts of vasopressin in the blood stream with a resultant hypertensive crisis. On clamping the blood supply it is usually necessary to supply intravenous epinephrine or nor-epinephrine to sustain the blood pressure. Supplemental vasopressin may be necessary for a short time thereafter. Removal of a pheochromocytoma results in a dramatic cure of hypertension.

Again, it is true that a great many negative screening tests will be done in the search for pheochromocytomas. *However, since it is now known that these tumors can cause a sustained type of hypertension resembling that of the essential type, every individual case of hypertension should receive at least one test for pheochromocytoma.* Any individual suffering from periodic hypertensive episodes should be subjected to an intensive search for pheochromocytoma. The easiest and most practical test for pheochromocytoma developed so far appears to be the Regitine test.

### ESSENTIAL HYPERTENSION

The urologist may play an important role in the future treatment of essential hypertension. A few courageous groups are performing bilateral adrenalectomy for cases of severe hypertension which have not responded well to other measures. Thorn, et al, have performed many bilateral adrenalectomies for hypertension and in 1952 reported 15 cases from which certain conclusions can be drawn.

Bilateral adrenalectomy, either one or two stage, is feasible in severely hypertensive patients. Marked cardiovascular changes may be present. These patients can be maintained on small oral doses of cortisone daily, with a liberal salt intake.

Occasional desoxycorticosterone is necessary if too much sodium chloride is being lost. In times of stress, extra cortisone is necessary. The mode of benefit appears to be that a greatly increased amount of sodium chloride can be excreted in the urine. A drop in blood pressure following adrenalectomy is always preceded by increased sodium chloride excretion in the urine.



However, increased sodium chloride excretion does not always cause a drop in blood pressure. Administration of desoxycorticosterone following adrenalectomy will cause salt retention with resultant raising of the lowered blood pressure. Poor results were obtained in those patients suffering from severe renal changes.

It appears that bilateral adrenalectomy, at present, should be reserved for those younger patients with so-called malignant or severe essential hypertension, who have not responded well to other therapy, and in whom renal damage is minimal. Congestive failure and severe vascular changes are not contraindications to the procedure if the patient can be placed in cardiac compensation by intensive therapy prior to surgery. Certainly this is not a procedure to be done lightly and time alone will tell whether it will take an established place in the therapy of hypertension.

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# The *Journal*

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## DIABETES DETECTION

THROUGHOUT THE NATION this month individual doctors, medical societies, and diabetes associations will cooperate with schools, industry, civic groups and citizens in general in a public spirited search for previously undiagnosed diabetics.

The week from November 14 to 20 is set aside for the major effort of the drive. In Indiana 24 county medical societies will conduct organized detection campaigns, and throughout the state individual physicians are urged to assist. Nine of the Indiana counties reported 23,028 tests in 1953. This year it is hoped that a total of 75,000 tests will be completed.

The hero of this year's drive is the St. Louis Dreypak (pronounced dry-pack). This is an ingenious device whereby a specimen of urine may be dried on a small piece of prepared paper,

sent through the mail, and be processed with a high degree of accuracy by a simple laboratory procedure. Each county society may obtain 1,500 of these testing devices and may purchase more if needed.

Diabetes is a condition which may exist for some time without producing symptoms sufficient to bring the patient to a doctor. It is estimated that there are more than one million unknown diabetics in the United States. At the same time it is a disease in which early diagnosis provides many advantages. Early treatment often ameliorates the course of the disease and may prevent some of the remote complications.

Detection drives render a great service in providing opportunities for early diagnosis of diabetes and also serve to emphasize the interest which the medical profession takes in the health of everyone.

## A.M.A. CLINICAL MEETING

THE SOLUTION of everyday medical problems will be the keynote of the Miami meeting of the A.M.A. The entire program, including the scientific exhibit, has been planned for the discussion of practical answers to the ordinary, but sometimes troublesome, questions which arise in general medical practice.

Dr. Thomas G. Hull recently announced that the program would be of broad general interest and also said that while various specialties are to be represented at the meeting, such as medicine, surgery and obstetrics, the program is not for the specialist in these fields, but rather for

the general practitioner who also must work in these areas.

The scientific exhibit will provide opportunity for individual physicians to discuss problems in fractures and deliveries with consultants. Doctors are invited to bring x-ray plates of fracture cases they wish to discuss.

Almost continuous scientific movies and closed circuit color television from Jackson Memorial Hospital will be featured.

The dates are November 29 through December 2.

## BLOOD BANK CLEARING HOUSE

PROGRESS WAS MADE recently toward the formation of a national agency for the country-wide exchange of blood bank credits. The new organization, tentatively called the National Blood Foundation, received approval in principle from the American Association of Blood Banks and the American Society of Clinical Pathologists this summer. The venture already had the approval of the A.M.A.

The plan is to establish a national blood-collecting, storing and distributing system. It would be similar to the clearing house plan by which money banks exchange funds and credits. Under such an arrangement a unit of blood could be collected at any blood bank in the United States and be used to establish a credit in any other blood bank.

With as much traveling and moving from place to place as goes on in the United States it is not at all unusual to have a seriously ill patient whose relatives and friends are literally scattered "all over." The proposed foundation would enable blood credits to be set up immediately. Later and at infrequent intervals physical transfers of actual blood would balance the inequalities which did not balance out by the passage of time and mutual exchange of blood credits.

It is easy to understand why the plan is receiving approvals all along the line. The scheme has many advantages, and if properly implemented should have no disadvantages. It is to be hoped the details are settled before long.

## DEFENSE DEPARTMENT INTERN PROGRAM

PRESENT DAY INTERNS who have not had military service and who have a two-year service obligation under the regular draft were polled in October by the Defense Department to determine their preference for service and

also to determine which ones desired deferment for the purpose of engaging in residency training.

The program is being conducted jointly by the Defense Department and Selective Service, with





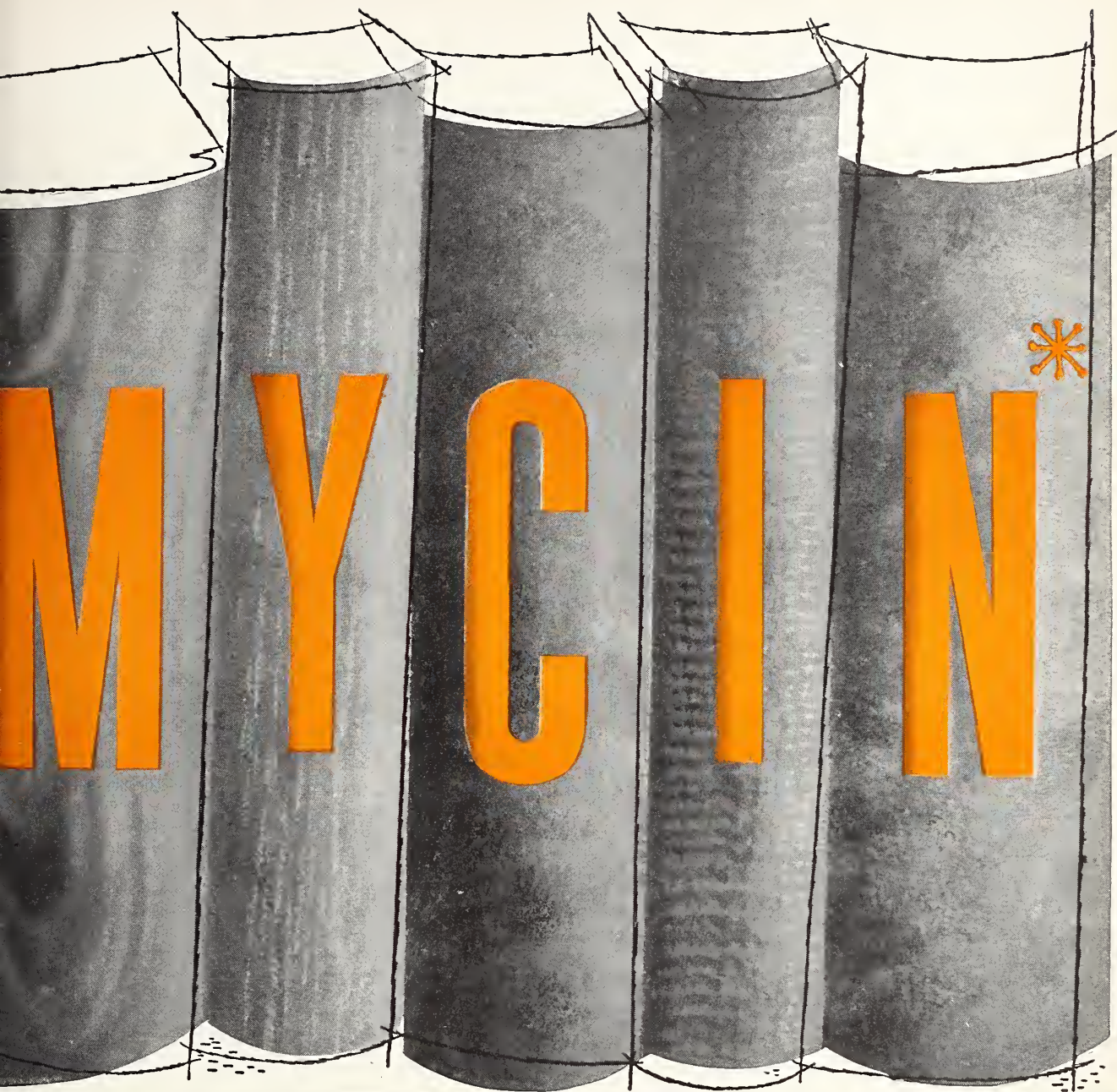
ACHRO

*Medical history is being written today*



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Hydrochloride  
Tetracycline HCl *Lederle*

The introduction and rapid widespread adoption of ACHROMYCIN has opened a new chapter in the history of broad-spectrum antibiotics.

ACHROMYCIN fulfills the requirements of the ideal antibiotic in virtually every respect . . . wide-range antimicrobial activity, *in vivo* stability, tissue penetration, minimal toxicity.

ACHROMYCIN is truly a broad-spectrum weapon, effective against Gram-positive and Gram-negative

bacteria, as well as certain mixed infections.

ACHROMYCIN is more stable and produces fewer side effects than certain other broad-spectrum antibiotics.

ACHROMYCIN provides prompt diffusion in body tissues and fluids.

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a view to commissioning the doctors in the service they prefer, and to enable as many as possible of those who desire residencies, to acquire some residency training prior to their military duty.

Advance information indicates that it will not be possible to grant deferment to all who are interested in further civilian hospital training.

However a substantial number of interns, to be selected by lot, will be deferred and subsequent to their residency will enter the service of their choice.

This is all a part of a larger program for the procurement of medical officers after the expiration of the Doctor Draft Act July 1, 1955.

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## SERENDIPITY

The physician should include the word "serendipity" in his vocabulary. The word is seldom found in ordinary use or in abridged dictionaries. The late Walter B. Cannon, for many years Professor of Physiology at Harvard, in his charming book, *The Way of an Investigator*, used as a title for one of his chapters, "Gains From Serendipity." He points out that in 1759 Horace Walpole, in a letter to his friend, Horace Mann, suggested that a new word, "serendipity," should be added to our vocabulary. Walpole had previously read a fairy tale, "The Three Princes of Serendip" (Serendip was the ancient name for Ceylon). The tale related that the three princes, "... were always making discoveries by accident or sagacity of things they were not in quest of."

A modern unabridged dictionary defines serendipity as "The gift of finding valuable or agreeable things not sought for." By way of explanation it adds: "The Three Princes of Serendip, who in their travels were always discovering by chance or by sagacity things they did not seek." For our editorial purpose we prefer the explanatory note, one reason being that although the findings may be valuable they may not necessarily be pleasant.

Many examples of serendipity can be given. Cannon, in his book, lists some interesting ones. Let us examine a few. The student in physiology or in physics will remember the observation made by Galvani. On an iron balustrade in his home some frog legs were suspended by a copper wire. He noticed that when they were swung by the wind and happened to touch the iron they twitched. Out of this observation rose the terms "galvanic" and "galvanism." His contemporary, Volta, the Italian physicist, showed that the twitching was due to an electric current.

Charles Richet, the French physiologist, also by chance made a brilliant discovery when study-

ing the toxicity of the extract of the tentacles of the sea anemone. Animals given a certain dose survived, but an extremely small dose when given after a lapse of time caused instant death. He had discovered the phenomenon of anaphylaxis.

Many other examples could be given: Pasteur's chance discovery of immunization; the discovery of vitamin K by Dam, the Danish investigator; and Cannon's brilliant observation concerning sympathin are all noteworthy.

The illustrations of serendipity just given deal with scientific discoveries. It must not be inferred that this term is confined only to science; it can be applied to many other fields of endeavor.

Let us consider serendipity in relation to the art of physical diagnosis. Surely many times a physician in attempting to make a diagnosis finds something in the course of the examination entirely different than that for which he is looking. Perhaps just a chance observation may enable him to arrive at the correct diagnosis.

When we speak of a chance observation it is well to recall Pasteur's famous dictum that "chance favors the prepared mind." This holds true not only in making scientific discoveries, but also in diagnosing the ills of a patient. The physician who is well-trained, who keeps abreast of the current literature in his field, and who is intelligently alert, will doubtless be more apt to profit by serendipity than his colleagues who do not possess these attributes.

Serendipity is not apt to play an important role in the life of an individual who has a closed mind or who rigidly adheres to fixed opinions. In order to live a rich and full life the mind must be open and hospitable to new ideas.

Let us not only add serendipity to our vocabulary, but also keep its precepts in mind.—*West Virginia Medical Journal*.



# The President's Page

"TIME MARCHES ON"—November '54 marks the birth of a new president of the Indiana State Medical Association. As with all births, there is the accompanying sense of joy, hope and faith. Joy in being honored to preside over our association; hope for continued unity, cooperation and accomplishment; and faith in our ability to deliver the best in medical care to the people of Indiana.

My first order of business was to appoint committees with the thought of continuity, geographical distribution, types of practice and constitutional restrictions. I hope my chairmen will have enough resourcefulness and intestinal fortitude to make our profession a leader and not a follower in this business of dispensing medical care. Our obligations no longer stop with our diagnosis and treatment of a single patient.

As president, I hope to offer ideas and suggestions with the thought of provoking discussion and positive action. This might well be referred to as a platform page.

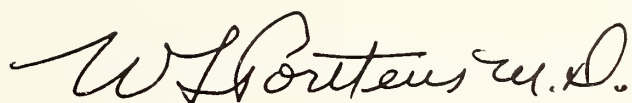
We must give top priority to our public relations and personal responsibilities. We must consider wisely our relationship with farm, labor, and other professional groups; we must unify our relationships within our own professional organizations; we must fulfill at all times our obligation to our communities; and we must recognize our responsibility in relation to our own primary education and the need to keep current with adequate postgraduate training. We must guard the principle of free medical education and be willing to use our knowledge to teach our citizens, and especially our youth, about the house in which they live—namely, their own bodies—lest they fall prey to quackery. We must show leadership in movements to reduce accidents on farms, in homes and on the roads.

We must discuss with our patients costs of medical care and the needs and reasons for the treatment we prescribe. Prior discussion of these provides the best antidote for malpractice suits and poor public relations.

We must look into our own lives and arrange for better preventive medicine for doctors. The adage, "Physician Heal Thyself" might be changed to "Doctor Guard Your Health" in order not to reduce our usefulness to our families and our patients.

We should carry our message of positive thinking to the people through forums, articles, and talks to lay groups. The "Bogeyman", advertising, should be dusted off and used to tell the public of the good work we, as a profession, are doing and can do better with its help. We should be constructively active in support of our organization, streamline it, unify it, and be fluid in our approach to social and economic changes. A dose of self appraisal is good medicine.

And last, but not least, we must be citizens first and doctors second; we must ever uphold the honor and dignity of our chosen profession and guard the principles of democracy under whose blessings we exist as free men. We can and must do all these things.



"He on whom Heaven confers a sceptre knows not the weight till he bears it."—Corneille

# *The Woman's Auxiliary*

## REPORTS TO I. S. M. A.

First, I want to add a few words to my September page on TODAY'S HEALTH. It has come to my attention that many of you doctors simply write your personal checks to pay for your subscription, and send it in yourself. That is an easy way to do it, but, since you have no chairman, or are participating in no contest, that subscription is LOST to Indiana, as far as credit is concerned. But, if you will just write on your check, "GIVE CREDIT TO -----(your)----- COUNTY AUXILIARY, then it will be credited to your own county.

Also, I find you do not like the Auxiliary Today's Health chairman to come to your busy offices to solicit subscriptions, and I don't blame you! But, you county Medical Society presidents could invite the Auxiliary chairman and her committee to come to your meetings early and set up a table in the lobby, or somewhere near, and get your subscriptions as you come to your meetings! We surely would appreciate your help in making our state quota this year!

This month I want to bring to your attention that very worth while project, the American Medical Education Foundation. Since this is your project, too, you already know about it. Perhaps you do not know the Auxiliary also has this project, and has been doing a very good job of it since its inception more than two years ago.

The first year we were able to raise \$1,656. The struggle has been UP HILL, however, as our total last year was over \$5,000. Our AMEF State Chairman, Mrs. Francis Fargher, Michigan City, gives this report: "Indiana really made a fine record last year, and received recognition at the San Francisco convention for the highest per capita contribution of any state. Also, two of our counties (Marion and Vanderburgh) were cited for contributing in excess of \$1,000 each. We're proud of this record, but still hope to surpass it in 1954-1955."

Here is where I come in. This year our slogan is: "Every County a Contributor". Our Goal: \$10,000, or double the amount given last year. One popular way to do this, is for each member to *make* \$5.00 to contribute. Many auxiliaries have some special money-raising project, such as a rummage sale, bridge party, or white elephant sale. Marion County had 15 such parties last year and in that way raised over \$1,000.

I was talking to a county AMEF chairman about this one day when her husband was present. He said, "Wouldn't it be much easier if each member would just ask her husband for \$5.00 to give to this fund?" Of course it would! That is why I am writing this page! Don't forget to give a share to the AMEF, and also, give your wife a share for this Auxiliary project. If you will do that, then Indiana will really go over the top! (California contributed only \$7,160.00).

It is true that those who have gone before you helped make it possible for you to get your own medical education, and it will give you a feeling of deep satisfaction when you have made your contribution to help those who come after you. Thanksgiving and Christmas are just around the corner. What better way to show your thanks, or what better gift could you give?

The 83rd session of the Congress of the United States passed a bill, initiated by the late Senator Taft, to incorporate the National Fund for Medical Education. The President on August 28 signed the bill authorizing a federal charter for the National Fund for Medical Education.

My best wishes for a restful and satisfying Thanksgiving Day.

Mrs. Harry C. Harvey, President

## Fifty Year Club Initiates Honored by I.S.M.A. at Reception

**T**RADITIONALLY one of the highlights of the annual convention of the Indiana State Medical Association is the reception and program arranged each year in honor of those members who have during that year reached their fiftieth anniversaries in the practice of medicine.

The 1954 class, 35 in number, was entertained in the Palm Room at the Athenaeum on October 27. Certificates and pins signifying their 50 years of service had been mailed individually prior to the convention.

Dr. Leonard A. Ensminger, Indianapolis, served as chairman.

Dr. Wm. Harry Howard, 1953-1954 president of Indiana State Medical Association, spoke briefly extending official welcome to the new members.

Speaker for the afternoon affair was Walter (Mickey) McCarty, editor of the Indianapolis News.

New members of the Fifty Year Club, in whose honor the program was planned, included:

Henry F. Beckman, Indianapolis\*; Homer G. Hamer, Indianapolis; Harry H. Heinrichs, Indi-

anapolis; Alonzo S. Neely, New Middletown; Nathan Stern, Indianapolis; Harrison S. Thurston, Indianapolis; Herbert M. Woollen, Indianapolis; Wade H. Taylor, Ambia; Herma A. Beck, Lebanon; Donnell R. Ivey, Royal Center; Timothy M. Weaver, Brazil; Lewis N. Geisinger, Auburn; Walter A. Stauffer, Elkhart; Franklin C. Dielman, Fulton; John C. Glackman, Sr., Rochester; William H. Braunlin, Marion; Joseph L. Allen, Greenfield; Wallace S. Grayston, Huntington; John G. Jones, Vincennes; Leroy F. Bills, Culver; Carl Boardman, Gary; Benjamin W. Chidlaw, Hammond; Joseph A. Teegarden, East Chicago; Isaac D. White, Clinton; Nicholas A. James, Tell City; George B. DeTar, Winslow; Charles E. Linton, Medaryville\*; Emerson Barnum, Shelbyville; Paul Higbee, Sullivan; James S. Baker, Evansville\*; William P. Woods, Evansville; William D. Adbury, Terre Haute; John R. Gillum, Terre Haute; Edward J. Schott, Terre Haute; and Jesse P. Galbreth, Burnettsville.

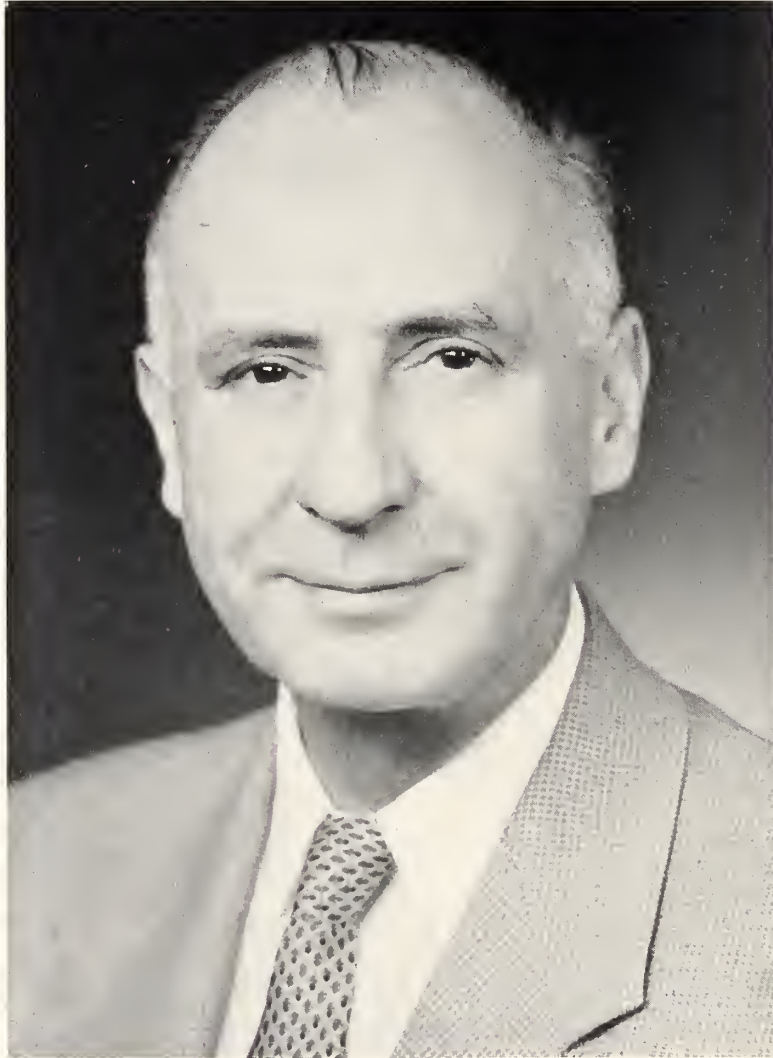
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\* Dr. Beckman received and acknowledged his Fifty Year Club certificate and pin just three days before his death occurred on October 5. The awards were presented to the families of Drs. Linton and Baker, whose deaths had occurred earlier.



# PRESIDENT—1954-55

Indiana State Medical Association



WALTER L. PORTEUS, M.D.

Franklin

**Walter L. Portteus, M.D.**  
**President**  
**Indiana State Medical Association**  
**1954-55**

**D**OCTOR WALTER PORTTEUS was installed as President of the Indiana State Medical Association at a ceremony following the annual dinner on October 27.

In his acceptance speech he stressed the need for unity and improvement of public relations as individuals and as an organization.

Doctor Portteus was born in Indianapolis in 1900 and attended Arsenal Technical High School and Butler University. He was awarded the M.D. degree by Indiana University School of Medicine in 1924. Following an internship at the Robert Long Hospital, he practiced briefly in Cumberland, Indiana and then moved to Franklin, where he has maintained a general practice ever since.

He was married in 1926 to Harriett Sweet, daughter of Dr. Edward M. Sweet of Martinsville. Their daughter, Nancy, is married to Jack Walters, who is a senior student at the School of Medicine, and who was recently the president of the Indiana Chapter of the Student A.M.A.

Doctor Portteus took an interest in the medical profession early in his career when he was elected secretary of the Johnson County Medical Society during his first year of practice. Since then his participation in the work of medical organizations on a local, state and national level has been on a rapidly expanding scale.

He was secretary of the county medical society for 12 years, and during this time served on numerous committees of the State Association. Postgraduate study, graduate education, and the Secretary's Conference were some of his interests. He was elected secretary of the Section on Medicine in 1935 and 1938. In 1939 he was vice-chairman and in 1940 chairman of the Section.

In 1933 Doctor Portteus was secretary of the Seventh District Medical Society and in 1934 and 1935 he was District President.

He served as Councilor of the Seventh District on two occasions and beginning in 1947 was elected to the Executive Committee each year until 1953. He was chairman of the Executive Committee for three years. Recently he has served on the AMA Campaign Coordinating Committee, the Preceptorship Committee, the Committee on Constitution and By-laws and the Liaison Committee with Labor.

Doctor Portteus has been secretary of the Indiana Blue Shield since its organization in 1946. He has also been a member of the National Blue Shield Commission. One of his favorite community projects was the building and establishment of the Johnson County Memorial Hospital. During the past two years he has attained national recognition for a pamphlet which he wrote for instruction of his patients. He enters the presidency of our Association with a background of long experience and with the good wishes of the entire profession.

## Letter to the Editor

October 5, 1954

To the Editor :

The members of the General Practice Section of Indiana State Medical Association have learned to cherish the privilege given us in the last few years of being responsible for the material printed in the annual August issue of the Journal. This issue you have liberally named the "Annual General Practice Issue."

As you know, I appointed a committee from the General Practice Section to be responsible for the August 1954 issue. This committee was headed by Dr. Frank Green, as Chairman, with Drs. Erwin Permer of Indianapolis, Keith Hammond of Paoli, W. D. Snively, Jr. of Evansville, Robert Orr of Mishawaka and Dr. Russell J. Spivey of Indianapolis. I believe that the results of their diligent labor speak for themselves in the excellent August issue of the Journal this year. However, there is one article that was used in this issue of the Journal that was not recommended or even seen by this committee and, as Chairman of the Section, I feel that some discussion of this article is certainly pertinent, especially in view of the fact that it appeared in the General Practice issue and may be construed by some to be the opinion of the members of the General Practice Section.

I am speaking now of the article that appeared on page 879 titled "In Defense of Hovering." This, you may remember, was a reprint from the Norfolk Medical News of Boston.

We, in general practice in Indiana, have never heard of the word "hovering" before and we note it is defined in this article as the "We are told that when a family physician sends a patient to the hospital under another doctor's care and then keeps going in to see his patient that this is called 'hovering'." We general practitioners feel that under whatever term it may be defined that the following of all referred patients in hospitals by the family physician is a highly desirable thing, from every point of view. We do not feel that there is anything underhanded or indecent about this practice and we also feel

that there can be no question about splitting fees for this purpose. It seems to us that any question of splitting fees would come in the family doctor receiving remuneration when he did not actually see the patient or do anything for him while he was in the hospital.

We understand, of course, that this article was written in the east where general practice has fallen to a somewhat lower estate than that in the midwest. It is our strong conviction that every patient referred to a specialist, particularly for operative procedures, should be followed by the family doctor both before and after surgery and on the same attending basis as the surgeon to whom the case was referred who operates it. We do not mean that the family doctor should expect to take charge but it is obviously the primary responsibility of the surgeon to be responsible for any case admitted on his service but we do feel that the family doctor is in a position to be of great assistance and aid not only to the patient but to the surgeon himself in caring for this patient through all of the various phases of preoperative and postoperative care. In most cases, a diagnosis has been made by the family physician before the patient was referred, or at least sufficient evidence has been elicited by the family physician that made him refer the patient to the specialist in the first place. He knows the family and he is better able to cope with all the situations regarding this family than anyone who has seen the patient, in a specialist capacity.

One aspect of this article that appears in the first paragraph on page 880 draws immediate reaction from me and that is where the implication is that the so-called "hovering," as they define it, should be rendered by a family physician without charge. The article states "Now should he charge for hovering—no, and we do not think he will, with an exception or two." The so-called "hovering" or continued interest on the part of the family physician in his patient while hospitalized and under specialist care is certainly a service that should be charged for. It is my personal opinion that the family should



be consulted in regard to the family physician watching his patients in the hospital and given the opportunity to say that they do not care to pay for such a charge, but if the family desires, as most of them do, that the family physician follow his patient, then it certainly is a legitimate charge and a bill should be sent for the family. In my personal experience I have always sent personal bills for this service with a full explanation for what the bill is rendered and I have never failed to receive cheerful remuneration, if remuneration was to be received at all. I do not think a surgeon should send a bill for the family physician nor should the family physician allow any part of the surgeon's fee to be diverted to him. A bill from the surgeon for his services and a separate bill from the family physician for his should be the order of the day but, by all means, let's not allow any impression to get out that the family physician is not entitled to recompense for his so-called "hovering."

I am quite sure that I am expressing the feelings of every member of the General Practice Section, of which I happen to have the honor this year to be Chairman, and I think I would be remiss if I did not give vent to this expression of their views.

*Editor's Note:* The General Practice Issue is not made up entirely of material prepared by the Section on General Practice, but also includes many items which the regular Journal staff processes. The article in question was not reprinted in an effort to imply approval by the special committee of the General Practice Section. In fact, the article was selected more as a matter of news, and the Journal staff does not wish to imply its approval of all elements of the editorial, either. We are pleased that it has evoked discussion on an important subject.

Again, may I say that the General Practice Section appreciates the opportunity to have this issue of the Journal and, with the exception of this one article, we are proud of it and we feel that Dr. Green and his committee did a very excellent job.

Sincerely,  
Norman R. Booher, M.D.  
Chairman G. P. Section  
Indiana State Medical Association

# American Legion Resolutions Presented for Doctors' Study

**T**WO OF THE MANY RESOLUTIONS passed by the American Legion at its annual convention in September are of special interest to physicians. Because of the possible far-reaching effects of these resolutions they are reproduced in full form.

Resolution No. 267 is a composite document, written by the reference committee which considered a total of 25 resolutions on the subject of the controversy between the A.M.A. and the American Legion in regard to medical care of veterans. It is reported that the tenor of the 25 resolutions, each of which was introduced by a different state, varied considerably from very mild to very critical.

The convention Rehabilitation Committee, which included several physicians on its membership, deliberated at length on the resolutions. The composite resolution (No. 267) which appears below is said to represent the constructive elements of all the resolutions on this subject, together with some modification of language in which some of the resolutions were couched.

## Resolution No. 267

**WHEREAS**, The American Legion in National Convention assembled in Washington, D. C. August 30—September 2, 1954, again wishes to express our esteem and affection to the American physician who brought us into the world, safeguarded our childhood, stood by us in battle and attended our comrades in their final hours, and to those members in the medical profession who have unselfishly contributed so much to the well-being of the American veteran of all wars. We want to reassure each of them of our faith in their individual integrity. And

**WHEREAS**, it is with deep regret that we observe that those who purport to speak for the American physician through the medium of the American Medical Association have apparently sacrificed their high principles in the interest of monetary consideration, as evidenced by their continued unwarranted and unproved assertions in respect to sick and disabled veterans; and

**WHEREAS**, the tempo and force of such attack is accentuated by the adoption of three separate reso-

lutions considered and approved by the House of Delegates of the American Medical Association in its annual meeting at San Francisco in June 1954, which are so callous as to cast serious doubt upon their acceptance as a true statement of attitude reflecting the position of the majority of the doctors of this Nation; and

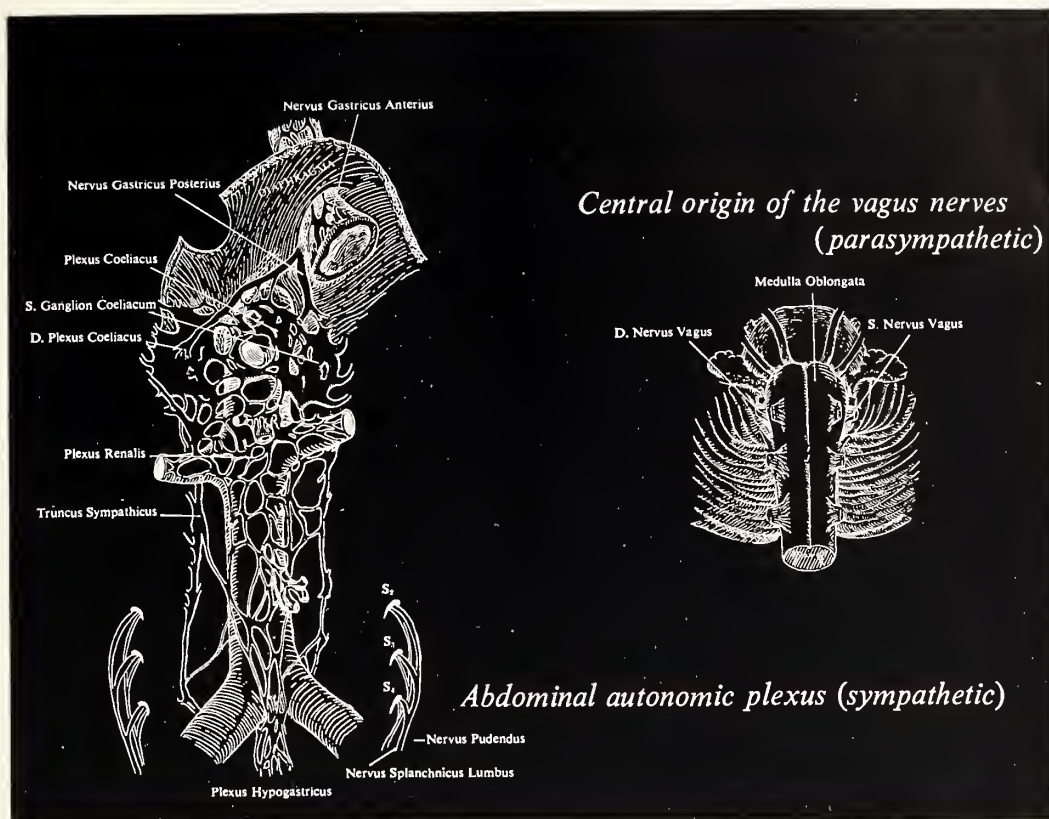
**WHEREAS**, the American Medical Association through its House of Delegates and under the inspiration of certain cash-conscious members of its directing clique have mounted and maintained an undeserved attack upon the sick and disabled veterans of America; and

**WHEREAS**, each of the said resolutions, by implication if not directly, is so interspersed with references to "means," "income," "finance" and the like as to leave the clear conclusion, if full credence be given its spokesmen, that the medical profession has forsaken its love for humanity and its care for human suffering to substitute therefor a devotion to dollars; and

**WHEREAS**, one of the resolutions adopted by the American Medical Association at its San Francisco meeting in effect asserts that the mere fact that one is a veteran should be considered as prima facie evidence of dishonesty; while another suggests that all doubt as to the origin of disease of disability be resolved against the veteran and his military service; and another, reported to the House of Delegates, seriously proposes a substitute system of Government-financed health insurance for every veteran unable to pay the premium cost of such coverage, in lieu of the present Federal hospital program, it being the obvious ulterior desire of the proponents of this substitute plan that many of such insurance dollars would ultimately find their way into their own pockets at whatever rate of fee is fixed by that alliance of fee-fixers; and

**WHEREAS**, it is the belief of The American Legion that resolutions of the type adopted by the House of Delegates of the American Medical Association respecting veterans is not honestly indicative of the real sentiment existing in the minds of American doctors, but that such expressions come only from the tongues of a selfish minority; and

**WHEREAS**, be that as it may, The American Legion accepts the challenge, whether from the few or from the many, as it has accepted and defeated



## Control of Gastric Motility and Spasticity in Peptic Ulcer with Banthine®

"The need<sup>1</sup> for suppressing gastric motility and spastic states is . . . fundamental in peptic ulcer therapy. Since the cholinergic nerves are motor and secretory to the stomach and motor to the intestines, agents capable of blocking cholinergic nerve stimulation are frequently used to lessen motor activity and hypermotility."

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It has been shown<sup>1</sup> to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

The usual schedule of administration in peptic ulcer is 50 to 100 mg. every six

hours, day and night, with subsequent adjustment to the patient's needs and tolerance. After the ulcer is healed, maintenance therapy, approximately half of the therapeutic dosage, should be continued for reasonable assurance of nonrecurrence.

Banthine® (brand of methantheline bromide) is supplied in: Banthine ampuls, 50 mg.—Banthine tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle Research in the Service of Medicine.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. 147:1620 (Dec. 22) 1951.



every other challenge designed to remove the veteran from his hard-earned special classification or which has sought to deprive him of his rightful benefits, deservedly awarded; now,

**THEREFORE, BE IT RESOLVED**, that we do invite and urge each member of the medical profession to carefully read, interpret and analyze both the content and the intent of the three resolutions adopted by their national association and to individually speak their approval or disapproval of these proposals by communication with their national officers and/or The American Legion after having seen for themselves that such resolutions indict veterans as a class; becloud their good name; reflect upon their integrity and honesty; advocate the elimination of reasonable presumptions; seek to shift a clear federal responsibility to states and communities with all the attendant inequalities of medical services; and propose the substitution of a cash-paying insurance policy against the health needs of a human being; and

**BE IT FURTHER RESOLVED**, that The American Legion fully publicize and circulate these resolutions, pointing out by interpretation the implications of each, for the edification not only of the public and the veteran but also for the information of the individual physicians so that they may know the full nature of the philosophy now espoused by their House of Delegates and the basis upon which American veterans are to be further attacked; and

**BE IT FURTHER RESOLVED**, that copies of this resolution be sent to all United States Senators and Representatives and that it be made available to the press, including the Journal of the American Medical Association and allied publications as notice that The American Legion denounces the continued unwarranted attack upon veterans as a class and upon these programs, and that it will fight for the retention and preservation of every right conferred upon veterans by law, by tradition and by honorable service in the military forces with the same vigor and determination displayed by its members when fighting the wars of this Nation.

Resolution No. 56 recommends a change in the laws which govern hospitals in such a way as to make it mandatory for all hospitals which

receive any support from public monies, (including tax exemption), to include on their medical staffs all physicians who are licensed by their respective states.

#### **Resolution No. 56**

**WHEREAS**, we believe it to be the unrestricted right of every individual to be treated by a physician of his own choice; and

**WHEREAS**, every state under its sovereign power has provided by legislation a proper method for determining an applicant's qualification to be duly licensed to practice medicine in its jurisdiction; and

**WHEREAS**, those hospitals which have received financial assistance from public funds in either construction, maintenance, tax exemptions, or other public subsidization should be available for the treatment and care of all citizens and who, while confined therein, should be entitled to the services of their own duly licensed physicians; and

**WHEREAS**, in practically all hospitals, the health facilities thereof are available only to those physicians who have staff membership or courtesy privileges, and in the event a physician is not accorded such status, a patient to avail himself of the advantages of the hospital must as a matter of course discharge the physician of his own choice and engage a physician with staff privileges;

**NOW, THEREFORE, BE IT RESOLVED** by The American Legion in National Convention assembled in Washington, D. C. August 30—September 2, 1954, that all such public subsidized hospitals should be available to all citizens, who while confined therein as patients should be entitled to the services and treatment of the duly licensed physicians of their own choice, irrespective of staff membership; and

**BE IT FURTHER RESOLVED**, that the National Legislative Commission of The American Legion be directed to seek Congressional legislation to effectuate the object and purpose of this Resolution, and that each Department be urged to seek similar legislation in their respective states.

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restlessness and irritability associated  
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Adults—32 mg. to 0.1 Gm.  
(optimal 50 mg.), 3 or 4 times daily.

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3 or 4 times daily.

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Four physicians fascinate friends  
and influence others to join their  
Dixie-land jazz band at Lafayette

## "Crusty Crumbs" on Road to Fame Following Murat Theatre Appearance\*

RICHARD P. GRIPE, M.D.

*Lafayette*

**P**ATIENTS IN THE Lafayette area are accustomed to see four local doctors appear in public as members of a Dixie-land jazz band called "The Crusty Crumbs." Two years ago in March, 1952 the band was organized to provide an opportunity for fun and recreation. Chief instigator was Dr. Harley H. Frey, an anesthesiologist in Lafayette, who played the piano at the first concert and who now plays the clarinet.

What began as idle conversation, "Wouldn't it be fun to have a little band?" soon turned into actuality. The original band was composed of eight members, four of whom were physicians. When the supply of doctors who were musicians was exhausted, the missing positions were filled by a dentist, a Purdue professor, a minister (who played trombone, of course), and a salesman for a Lafayette frozen foods company.

A library of nearly 80 pieces has been slowly accumulated, many of them in so-called "stock" arrangements. However, when a particular piece can not be located, Dr. Frey writes an original orchestration especially for the band. Many of the instruments had not been touched in years. The drums, played by Homer McClellan, a salesman for Lafayette Foods, Inc., had gathered dust for 20 years. The equipment had not been

The tuba player always commands special attention and Dr. W. M. Sholty and his \$27 tuba are no exception. They're part of the original "Crusty Crumbs".



used since "Mac" had played with the "Harmony Kings Dance Band" at Goodland, Indiana in the 1930's.

Dr. William Sholty, also an anesthesiologist, who plays the tuba, had long since disposed of his instrument. Fortunately, however, a tuba priced at only \$15 was located in a pawn shop. Despairing of ever selling it, the pawn broker had unsoldered it. For \$12 additional the tuba was resoldered and has performed well since. Dr. E. T. Mertz, assistant professor of agricultural biochemistry at Purdue University, was glad to take over on the piano. His skill at improvising has since gained him the nickname of "Fingers." The first saxophonist was Dr. Tom Wachob, then a resident physician at St. Elizabeth Hospital. Dr. Wachob is now practicing obstetrics and gynecology in Kokomo.

Dr. E. O. Metzger, a Lafayette dentist, has played the banjo. In his spare time he makes his own banjos as a further extension of his hobby. The Reverend David J. Cull, formerly assistant minister at the Central Presbyterian Church in Lafayette, was the first to play trombone. The trumpet is played by Dr. Richard P. Gripe, a cardiologist at the Arnett Clinic in Lafayette.

Shortly after its formation, the group played

\* When Dr. Gripe prepared his story in answer to a JOURNAL editorial, "We Invite You to Tell a Story," he had no idea his musical aggregation would make the Murat Theatre in Indianapolis before they achieved their ambition to play in Purdue's Hall of Music. Many of the members of Indiana State Medical Association heard them at the annual convention and will be interested to read the story of a real hobby as told by the band's trumpet player.



a concert for the Lafayette Home Hospital Nurses' Alumni. With so many doctors in the band, the nurses graciously applauded. But the band members remember it as a rather shaky effort. Later the band played its second concert at Jefferson High School for the annual dinner of the Lafayette Symphony Orchestra.

It has been the policy of the members from the beginning never to play for money nor to take an engagement where a professional band might be called on.

Highlights of the past year have been performances during the intermission of the Lafayette Symphony's 1953 Pops Concert, a 15-minute spot on a Lafayette television program, and a recent concert in the ballrooms of the Purdue Union building before 800 people attending a Chamber of Commerce dinner.

When Dr. Wachob finished his resident training, his place at tenor saxophone was taken by Dr. Forrest J. Babb, a general practitioner from Stockwell. Dr. Babb has tape recorded several of the band's better numbers and occasionally plays them in his waiting room for his patients.

Last year the Reverend Cull became pastor of a church in Rochester, New York; and his spot was taken at trombone by Warren S. Carr, who is with the Lafayette office of the Internal Revenue Service. Alternating at piano with Dr. Mertz, has been Robert F. Kelley, an engineer with the Aluminum Company of America.

The picture accompanying this story was taken at a farewell party given in honor of the Rever-



This photograph of the Crusty Crumbs was taken at a dress rehearsal. From left to right are Dr. E. O. Metzger, dentist, the banjoist; Dr. Sholtz, anesthesiologist, tuba player; Robert F. Kelley, Alcoa engineer, pianist; the Rev. David J. Cull, Presbyterian minister, trombonist; Dr. Forrest J. Babb, general practitioner, tenor saxophonist; Homer McClellan, frozen foods salesman, drummer; Dr. Harley H. Frey, anesthesiologist, clarinetist; and Dr. Richard P. Gripe, cardiologist, trumpet man.

end Cull before he moved to New York. It shows the band wearing their usual costumes for public performances, i.e., derby hats, bow ties, and colored vests.

Wives of the members are always invited to rehearsals, and they form a loyal "auxiliary." The members of the band feel that it's a wonderful hobby, and a good way to blow off steam. They hope to keep on blowing for many years, and perhaps some day to achieve their highest ambition, that of playing on the stage of the Purdue Hall of Music.

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# NEWS NOTES—from State and Nation

## Cardiac Conference

Scheduled for November 24

The second cardiac conference at the Indianapolis General Hospital will be held on Wednesday, November 24 at the Indianapolis General Hospital. The discussion will center about the treatment of unusual features of congestive heart failure.

The discussants for this meeting will include Dr. John Ling, Richmond; Dr. Gordon Hermann, Evansville, and Dr. Bill Martz, Indianapolis.

For particulars of the program write the Robert M. Moore Heart Clinic, Indianapolis General Hospital, Indianapolis.

The third conference in the series will be held Wednesday, January 19, 1955.

Dr. Alfred D. Dennison, Jr., graduate of Cornell University Medical College and for-

merly in private practice for eight years in Maplewood, New Jersey, has opened an office at 1005 Hume Mansur Building, Indianapolis, where he will specialize in cardiology and internal medicine.

Dr. Dennison came to Indianapolis a year ago to work on a cardiovascular research program at the Lilly Clinic, Indianapolis General Hospital. He has also been on the teaching staff at Indiana University School of Medicine.

In New Jersey, Dr. Dennison served as chief of cardiology at New Jersey Orthopedic Hospital, acting chief at Orange hospital and consultant at Columbus and Clara Maas Hospitals in Newark.

He served in the Navy for three years during World War II.

Dr. and Mrs. Dennison and their three children live at 701 East 78th Street, Indianapolis.

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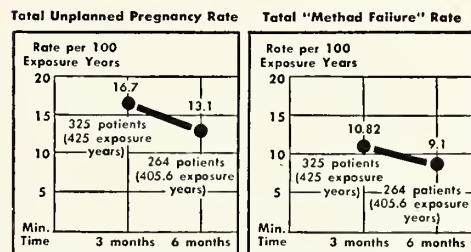
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# PSYCHOLOGIC MOTIVATION AND CONCEPTION CONTROL

Psychologic motivation, defined as "... the sincere, urgent, uncomplicated desire to remain nonpregnant..." is an increasingly recognized factor in the success or failure of contraceptive measures.<sup>1</sup>

One of the factors influencing motivation, namely, parity, was appraised by Guttmacher<sup>1</sup> and associates in a three-year study of the jelly-alone [RAMSES® VAGINAL JELLY] method for contraception. A carefully selected group of 325 postpartum clinic patients used RAMSES VAGINAL JELLY for periods representing a total of 425 patient years of exposure. The technic showed marked effectiveness but was especially successful "among patients of lower parity."

Although the method was highly dependable, some unplanned pregnancies did occur. The pregnancies were divided into "patient failures" and "method failures." Patients readily admitting omission or irregular use of the jelly were classified in the first group, while those claiming regular and faithful use of the jelly were grouped in the latter category.



Comparison of conception control with RAMSES VAGINAL JELLY in patients using the method for 3-36 months and 6-36 months.<sup>1</sup>

During 425 patient years of exposure in 325 women using the jelly, the total unplanned pregnancy rate was only 16.7 per 100 patient years of exposure. When

the "method failure" for the entire group is calculated, the unplanned pregnancy rate drops to 10.82 per 100 patient years of exposure. When only those patients who used the jelly-alone technic for six months and longer are considered (the usual length of time accepted for valid comparisons) the pregnancy rate is decreased markedly. This indicates that familiarity with and reliance on the method are probably also important. In 264 such patients, during 405.6 patient years of exposure, the total unplanned pregnancy rate was only 13.1 per 100 years of exposure, and the method failure rate dropped to 9.1 per 100 years of exposure.

## Fitting the method to the patient

It has been demonstrated that motivation, parity, and patient-intelligence play important roles in the selection and the successful use of a conception control method and, therefore, that the final decision regarding the selection of method must be left to the physician who is fully cognizant of all these points.

When in the judgment of the physician, parity, anatomic factors, or motivation indicates the use of the diaphragm-and-jelly method of contraception, the RAMSES® TUK-A-WAY® Kit is recommended. The RAMSES® diaphragm is flexible and cushioned — provides an optimum barrier and utmost comfort. In combination with RAMSES jelly it offers an unsurpassed contraceptive technic. Both products are accepted by the appropriate Councils of the American Medical Association.

\*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

1. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: *Am. J. Obst. & Gynec.* 63:664, Mar., 1952.

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### Cerebral Palsy Seminar At Rotary Home, November 10

A seminar on cerebral palsy will be held in the Rotary Convalescent Home November 10 at 4 p.m. under the auspices of Indiana University School of Medicine and the United Cerebral Palsy Association of Marion County. Clinical demonstration will be followed by a dinner address by Dr. Elizabeth Crosby, professor of neuro-anatomy at the University of Michigan Medical School. Her subject will be "Compensation for Cerebral Loss."

All physicians interested in cerebral palsy are invited and should send their reservations to the Cerebral Palsy Clinic, Indiana University Medical Center.

The prize-winning exhibit on infant feeding during the first year of life which was prepared by Dr. W. D. Snively, Jr., medical director of Mead Johnson and Company, and Dr. Harold D. Lynch, Evansville pediatrician, was judged first place winner at the Mississippi Valley Medical Association's Annual convention in Chicago in September. The display won first place in the pediatrics division at the A.M.A. June convention. Dr. W. E. Henrickson, Poplar Bluff, Missouri, pediatrician collaborated with the Indiana physicians in preparing the exhibit.

Dr. Charles H. Aust, who recently completed his internship at Indianapolis General Hospital, has established an office for the general practice of medicine at 2006 East Wabash Avenue, U. S. Highway 40, Terre Haute. Dr. Aust is a native of Boonville and a graduate of Indiana University School of Medicine. Mrs. Aust, a registered nurse, will assist Dr. Aust in his office. Dr. and Mrs. Aust and their son are residing at 202 South 24th Street, Terre Haute.

Dr. Richard C. B. Ko, who has been in private practice in Eaton since 1948 is now serving as a lieutenant in the U. S. Navy Medical Corps, assigned to the U. S. S. General W. A. Mann.

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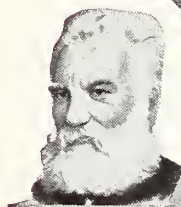
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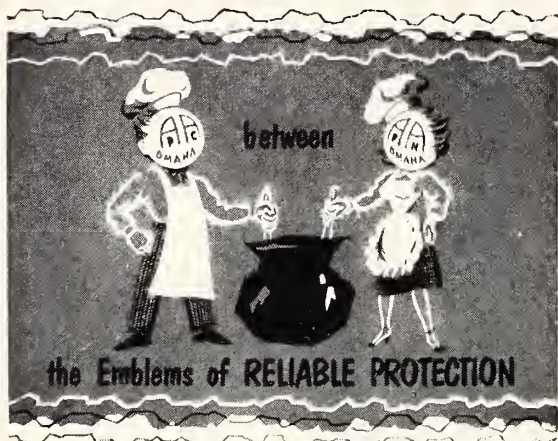
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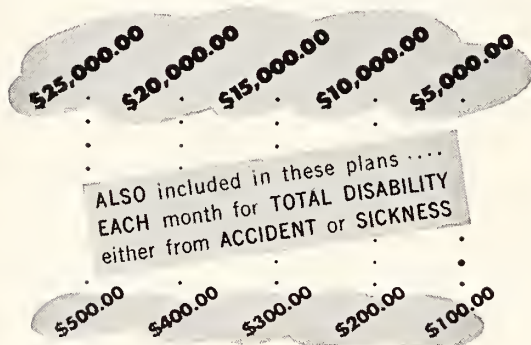
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## Dr. R. M. Zollinger Named To VA Advisory Group

Dr. Robert M. Zollinger, professor and chairman of surgery at Ohio State University and chief of surgery at the University of Ohio hospital, has been elected vice-chairman for two years of the Special Medical Advisory Group of Veterans Administration. The 20-member committee meets quarterly to advise the VA administrator and the chief medical director on the policies and programs designed to insure the best possible medical care and treatment of disabled veterans.

Dr. G. E. Kasting, a 1949 graduate of Indiana University School of Medicine, is now associated with Dr. R. V. Smallwood, 206 Citizens National Bank building, Bedford, in the practice of internal medicine and obstetrics and gynecology. Dr. Kastner served his residency at Methodist Hospital, Indianapolis, and had been with the Lamkin Clinic, Sardinia, Ohio since April, 1952.

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**Dr. Harold L. Brenton**, who has completed internship and residency at the University of Iowa hospitals, has joined the staff of Linvill Memorial Clinic, Columbia City, where he will be associated with Dr. F. M. Thompson in the practice of internal medicine. Dr. Brenton is a graduate of Bowman Gray School of Medicine at Winston-Salem, North Carolina, a World War II veteran and served in Korea 18 months.

### Board Examinations Set By Specialty Groups

The next scheduled examination, Part I, written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada and military installations outside the continental U. S. on Friday, February 4, 1955, Dr. R. L. Faulkner, secretary of the American Board of Obstetrics and Gynecology, reports. Twenty case abstracts are to be sent the secretary as soon as possible after receiving notice of eligibility.

The American Board of Physical Medicine and Rehabilitation will hold examinations in Philadelphia June 5 and 6, 1955. Final date for filing applications is March 1. Applications for eligibility to the examinations should be mailed to Dr. Earl C. Elkins, Secretary, 30 North Michigan Avenue, Chicago 2, Illinois.

**Dr. Richard L. Glendening**, former Wilmette, Illinois physician and surgeon who has just returned from two years service as a general surgeon in the army in Japan and Korea, has taken over the office of Dr. J. Carl Jones, 422 North Street, Logansport. Dr. Glendening is a native of Richmond, received his degree in medicine from Georgetown University School of Medicine, Washington, D. C., in 1949 and was in surgical residency two years at Methodist Hospital, Indianapolis. Dr. Jones expects to enter military service.

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### U. of Florida Announces O. and O. Midwinter Meeting

The ninth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held in the San Souci Hotel in Miami Beach during the week of January 17, 1955.

Lectures in ophthalmology will be presented January 17, 18, and 19; otolaryngology lectures will be given January 20, 21 and 22.

A midweek feature is the Wednesday midwinter convention of the Florida Society of Ophthalmology and Otolaryngology to which all registrants are invited.

Seminar lecturers this year include Drs. W. F. Hughes, Jr., Chicago; Phillips Thygeson, San Jose; James Allen, New Orleans; Walter H. Fink, Minneapolis; M. L. Berliner, New York; Paul Holinger, Chicago; L. R. Boies, Minneapolis; E. P. Fowler, Jr., New York; A. W. Proetz, St. Louis; and D. D. DeWeese, Portland, Oregon.

Dr. R. Adrian Lanning, who recently completed a general practice residency at Maricopa County General hospital, Phoenix, Arizona, has opened an office for the general practice of medicine at 1428 Main street, Elwood. Dr. Lanning, formerly of Vincennes, is a graduate of I. U. School of Medicine, served his internship at Memorial hospital, Phoenix. He is a World War II veteran having served as a meteorologist with the air force. Mrs. Lanning is a graduate nurse.

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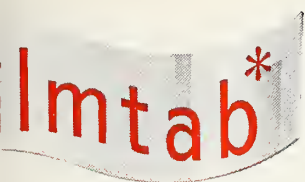
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**Norways Foundation Hospital** has received national accreditation by the American Psychiatric Association for its psychiatric affiliation training program for student nurses. Receipt of the approval from the Committee on Psychiatric Nursing of the APA was announced by Rodney W. Hemsworth, administrator of the hospital. Both Ball memorial School of Nursing, Muncie, and St. Joseph's Hospital School of Nursing at Fort Wayne send their student nurses to Norways for psychiatric training.

**Dr. Robert G. Taylor** is now associated with Dr. A. N. Ferguson in the practice of internal medicine at the Duemling Clinic, Fort Wayne. Dr. Taylor, a native of Monessen, Pennsylvania, received his M.D. from Harvard University Medical School in 1948. He completed a three year residency at Hines VA Hospital, Illinois. Dr. Taylor served in the Navy Medical Corps from August, 1949 to May, 1951. He and his family live at 17 Willoughby Place, Fort Wayne.

**Dr. M. S. Mount**, Bloomfield, held open house in his new office building October 8. The building is completely modern, and includes many features planned to facilitate the handling of patients. The building is located at the corner of North Franklin street and Indiana avenue.

**Dr. Joseph George** who had been practicing in Edinburg since March and who had planned to move his practice to Martinsville has gone to Lake Arthur, Louisiana, with his family to make their future home.

**Dr. John W. Beeler** has been discharged from military service and is now in full time partnership in radiology with Dr. Raymond C. Beeler, 712 Hume Mansur Building, Indianapolis. Dr. Beeler served for 15 months at Fort Riley, Kansas.

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# Deaths . . .

**Lofton H. Harris, M.D.**, 35 year old Evansville chest surgeon, was killed when his automobile was struck by a tractor-trailer September 18 at Kasson, near Evansville. Mrs. Harris was seriously injured.

Doctor Harris had been associate thoracic surgeon at Boehne Hospital since April, 1953. He had resigned effective October 1 and planned to enter private surgical practice in Evansville. A native of North Carolina, Doctor Harris received his medical degree at Medical College of Virginia in 1942. He served a year's internship at the college hospital, then entered the Army Medical Corps for three and one-half years, serving in the European theatre for two years. He held the rank of major. On his return, he trained for three years in general surgery at the Medical College of Virginia, then went to the VA hospital at Richmond where he became head of the department of thoracic surgery. He spent a brief time in a Michigan hospital before joining the Boehne staff to assist Dr. Paul D. Crimm, superintendent at the time.

**Harry H. Ward, M.D.**, 80, Coalmont physician for 50 years, died at his home in that community September 19. He had been in ill health and in semi-retirement since 1944.

Doctor Ward was a native of Corydon, a graduate in 1898 of the Louisville Medical College. He practiced briefly at Upland, Sullivan, and Alum Cave before establishing his practice and home in Coalmont. Active in medical organizations, he had served as Fifth Medical District president in 1935 and as a delegate to several I.S.M.A. state conventions. He was a senior and 50 Year Club member of the state association, a member of American Medical Association, of Clay County Medical Society, the Milwaukee Railroad Surgeons Association, Aesculapian Society of Wabash Valley, the Academy of Medicine at Terre Haute and fraternal groups.

**Gustus S. Billman, M.D.**, veteran Shelby county physician who at 82 was still practicing, died in his combined residence and office in Marion township, Shelby county, September 29,

according to a coroner's report. Patients who were unable to gain admittance to his office summoned help and found Dr. Billman dead in his bedroom. Death was from natural causes. A native of Shelby county, he was graduated from the Medical College of Indiana in 1895 and except for a few years practice in Indianapolis, had been a general practitioner in Shelby county throughout his career. He was a member of the Shelby County Medical Society, a 50 Year Club member of Indiana State Medical Association and a member of American Medical Association.

**Arthur Thomson Kemper, M.D.**, Muncie physician and surgeon for 57 years, died October 4 in his home following several months illness during which he had retired from practice.

Dr. Kemper was the son of Dr. G. W. H. Kemper, Civil War general and later a distinguished Muncie physician for 42 years. The father's medical and historical writings received wide publication. Dr. A. T. Kemper joined his father in practice in Muncie following his graduation from the Medical College of Indiana in 1897. He had served as surgeon for the New York Central Railroad since 1903.

Dr. Kemper was a senior and 50 Year Club member of Indiana State Medical Association, a member of American Medical Association, of the Delaware-Blackford County Medical Society and Muncie Academy of Medicine. He was also a 32nd degree Mason and a lifetime member of the Scottish Rite.

Doctor Kemper had celebrated his fifty-seventh year in practice and his fifty-seventh wedding anniversary in June.

**Louis C. Lukemeyer, M.D.**, 86, who had completed 60 years of active medical practice when he became ill September 3 and was forced to retire, died October 5 in Huntingburg following a cerebral hemorrhage.

He was a native of Huntingburg and had practiced there for the last 51 years. He was a graduate of Rush Medical College, Chicago, in 1894 and established his first office in Mt. Carmel, Illinois. Later he practiced in Jasper

and Hawesville before returning to his native community in 1903.

Doctor Lukemeyer was among the first recipients of a 50 Year Club certificate and pin from the Indiana State Medical Association when that honorary group was established in 1947. He was also a member of the Dubois County Medical Society and the American Medical Association.

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**Henry Frederick Beckman, M.D.**, distinguished Indianapolis obstetrician and professor emeritus of obstetrics at Indiana University School of Medicine, died October 5 in Robert W. Long Hospital, Indianapolis, where he had been admitted earlier in the day after suffering a heart attack. He had been in ill health for several years forcing his retirement in 1948 from the chairmanship of the obstetrics department at the medical school, a post he had held for 14 years.

A native of Kendallville, where he was born in 1876, Doctor Beckman received his medical degree from Northwestern University in 1904. He immediately established his practice on Indianapolis' South Side. His long career as a professor began in 1905 when he was named assistant professor in the old Indianapolis College of Surgeons. He had served as chairman of the obstetrics departments at Methodist, St. Vincent's, General and Coleman hospitals. The obstetrical ward at General Hospital was named for him in 1949.

Although he had established himself as a leading obstetrician, Doctor Beckman sought additional training, spending three years in Switzerland and Germany in postgraduate work.

He was a diplomate of the American Board of Obstetrics and Gynecology, a fellow of the American College of Surgeons, a senior and 50 Year Club member of Indiana State Medical Association, and a member of the Indianapolis Medical Society and the American Medical Association.

In addition to his medical organization affiliations, Doctor Beckman had been an active member of the Lutheran church for many years. He had served for 30 years on the church council and board of education.

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**Gretchen Irene Polhemus, M.D.**, New Albany obstetrician and gynecologist, died October

6 in St. Edward's Hospital, New Albany. She was 50 years old. A native of Grandview, Doctor Polhemus attended Mitchell schools and was graduated from Indiana University School of Medicine in 1935. She established her practice in New Albany in 1936 and had become a leader in her profession and in civic affairs in that city. She was known for her benevolence in aiding underprivileged children, donating medical care and financial assistance. She had adopted four children.

Doctor Polhemus was a member of Floyd County Medical Society, the Indiana State and American Medical Associations.

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**John D. Pahmeier, M.D.**, Sandborn physician for 36 years, died in his home there October 8 from complications arising from an automobile accident in July, 1953. He had never fully recovered from his injuries. Doctor Pahmeier, who was 70, was a native of Westphalia, a 1913 graduate of the University of Louisville School of Medicine, and served as a captain in the Army Medical Corps during World War I. He taught school before becoming a physician. He served as county health officer for nine years.

Doctor Pahmeier was a member of Knox County Medical Society, the Indiana State and American Medical Associations. He was also a member of the Academy of General Practice and served as president during 1948-1949. He was active for many years in Masonic orders.

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**Samuel R. Laubscher, M.D.**, 79, died of a heart attack in his Evansville home October 12. He was still in practice and had seen several patients the previous afternoon.

A native of Vanderburgh county, Doctor Laubscher was graduated from Louisville Medical College in 1898. He had been in practice in Vanderburgh county for 56 years. During World War I he served with the rank of major. Doctor Laubscher established the Highland Sanitarium on his return from army service which he operated for several years. Since that time he and a son, Dr. Clarence Laubscher, have had offices in the Kratzville road building formerly used as the sanitarium. Another son, Dr. Chester S. Laubscher, practices in Long Beach, California.

Doctor Laubscher was a 50 Year Club member of Indiana State Medical Association.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

September 26, 1954

Roll call showed the following present: James W. Denny, M.D., chairman; Wm. Harry Howard, M.D.; W. L. Portteus, M.D.; Elton R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump and Robert Hollowell, attorneys; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Guests: Andrew C. Offutt, M.D., State Health Commissioner; Willis Stogsdill, M.D., Franklin.

Executive Committee of the Woman's Auxiliary: Mrs. Harry C. Harvey, president, Fort Wayne; Mrs. J. W. Mather, president-elect, East Gary; Mrs. Roy V. Myers, recording secretary, Indianapolis, and Mrs. W. Burleigh Matthew, past president, Indianapolis.

### Membership Report

Number of members September 25, 1954	3,839*
Number of members September 25, 1953	3,780
Gain over last year	59
Number of members December 31, 1953	3,822

\* Includes

128 in military service (gratis)

107—\$10.00 members (residents and interns)

265—senior members

63—members, dues remitted by Council

2—honorary members

AMA dues paid: 1952 — 3,569; 1953 — 3,628\*\*;  
1954 — 3,573\*\*

\*\* Includes 420 members permanently exempted in 1952.

### Headquarters Office

Mr. Amick reported on his visitation of hospital staffs and county medical societies, and the fact that he recorded three days of the scientific session of the Kentucky State Medical Association in Louisville, Kentucky.

Mr. Bush reported that he had also been calling on county society secretaries and had been busy with the recording activities in the office, reporting that requests had been received for 88 recordings during the past week.

Dr. Portteus stated that he had spent some time in the headquarters office recently and it was a serious problem that the Committee should consider an amount of additional floor space for the office. Dr. Portteus reported that the space that

had been authorized previously had not become available for rental and as a result the headquarters office was not expanded as it had planned to be and storage was beginning to be a problem. After discussion the secretary was instructed to investigate the possibility of installing a micro-filming system in the office for the purpose of micro-filming records, and to report back his findings at the next meeting.

### Legislative Matters

#### Local

Mr. Stump and Mr. Hollowell reported on the optometric bill that the Interprofessional Committee on Eye Care was proposing to introduce in the coming session of the state legislature.

The secretary reported that the State Chamber of Commerce at its recent meeting in French Lick had approved the constitutional amendment which would provide for home rule for cities and municipalities in the State of Indiana.

### Annual Convention, Indianapolis, October 24, 25, 26 and 27, 1954:

The secretary reported that it was the plan to give an automobile for the capital prize to some physician, the second prize to be a \$100.00 merchandise credit, good with any of the exhibitors, and the third prize a \$50.00 merchandise credit, good with any exhibitor. This was approved by consent.

### Organization Matters

Upon motion of Drs. Howard and Myers the report of the Executive Committee for submission to the House of Delegates was approved.

The secretary read some correspondence from the Kansas Medical Society and presented a proposal of a Mr. Ray T. Wright of the Western Casualty and Surety Company in which he offered the members of the Indiana State Medical Association an Overhead Reimbursement Policy.

Following a discussion of this matter, and upon motion of Drs. Howard and Clarke, the proposal is to be referred to the Committee on Medical Care Insurance for investigation and study.

The secretary reported on the letter from the Jefferson National Life Insurance Company stating that they had withdrawn the policy which had been offered previously to physicians of Indiana on a disability plan.

The report of the Fourth District councilor on the matter referred to him by the Executive Committee was given and accepted as presented.



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Patients presenting such classic menopausal symptoms as hot flushes cause little diagnostic difficulty. However, throughout the period of declining ovarian function which may begin long before hot flushes appear, many women complain of distressing symptoms which though less clearly defined are actually due to estrogen deficiency. For example, insomnia, headache, easy fatigability, and symptoms affecting the bones, joints, and the skin may not be readily identified as due to estrogen deficiency because they may occur years before, or even years after cessation of menstruation.

Investigators<sup>1,2</sup> have found that as the body attempts to adjust itself to declining estrogen production, a number of symptoms may appear which call for the prompt institution of estrogen replacement therapy. These symptoms may be nervous, circulatory, arthralgic, or dermatologic in character because the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism"<sup>3</sup> and affects many body functions. If such metabolic imbalance or deficiency is evidenced, the administration of estrogen is clearly indicated.

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1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleson, J.: Lancet 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.



NEW YORK, N. Y. • MONTREAL, CANADA

The secretary presented a publication of the Indiana State Chamber of Commerce entitled, "Let's Talk Politics", for consideration of the Committee sending copies to the legislative committee chairmen or officers of the county medical societies. Following discussion, it was felt this publication was worthy of mailing to all members of the Association, and the secretary was instructed to purchase sufficient copies and mail to each member of the Association.

The secretary reported on a conversation with a member of the National Association of Claimants' Compensation Attorneys relative to an Indiana meeting to be held in Indianapolis on November 22, at which time it was hoped that the conference could have the participation of members of the Indiana State Medical Association.

The matter, by consent, was referred to the attorneys for information and recommendation, to be reported on at the next meeting.

Letter from Dr. Lester Renbarger, president of the Grant County Medical Society, was read to the Committee and by consent was referred to the Board of Appeals on Patient-Physician Relations.

#### The Journal

*Report on advertising* was accepted by consent:

Total, October, 1954 .....	\$3,539.12
Total, October, 1953 .....	3,465.41
Net gain .....	73.71

#### New Business

Dr. Andrew C. Offutt, health commissioner of Indiana, presented several questions to the Executive Committee on which he sought their advice, and upon motion of Drs. Howard and Clarke the Committee took the following action:

"The Indiana State Medical Association is opposed to any program of diagnosis by lay sponsored organizations and further is opposed to the use of larger than 70 mm x-ray film for survey purposes."

Further action was taken upon motion of Drs. Clarke and Portteus in which the following action was taken:

"Inasmuch as the law of Indiana requires that school teachers undergo physical examination at least once every three years, and in-

asmuch as this examination requires x-rays and laboratory work it is the belief of the Indiana State Medical Association that the use of 70 mm film is not adequate for diagnostic purposes and its use would not comply with the intent of the law."

Dr. Offutt explained several additional programs under consideration by the Board of Health, outlining them as follows:

a. A study on air pollution which is anticipated to begin next July.

b. Due to the rapid growth of suburban areas the Board feels that it is essential that they immediately begin some studies regarding water supply and sewage disposal in these areas.

c. It is proposed that the State Board of Health establish a virus laboratory which will operate on a referral basis only.

d. It is proposed that they select two places in Indiana for a pilot study on rheumatic fever.

This would not be operated as a clinic.

e. Inasmuch as they have found that three out of ten children have vision loss and that one out of ten has hearing difficulty, it is felt the Board of Health should add to its staff a qualified speech therapist to coordinate the programs throughout the state in these fields.

Upon motion of Dr. Howard, proposals a, b, c and d were approved by the Committee by consent.

Upon motion of Drs. Portteus and Clarke the Association approved the employment of a qualified speech therapist to coordinate the programs, with the understanding that this would not be operated as a clinic or a therapeutic operation on the part of the State Board of Health.

Dr. Howard complimented Dr. Offutt on his attitude in bringing these matters before the State Medical Association for their understanding and discussion.

There being no further business, the Committee adjourned to meet again at 12 noon, Sunday, October 24, 1954, in the conference room at the I. U. Student Union Building, on the Medical School campus, Indianapolis.

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Signs of vestibular damage appear in cats treated with Distrycin as much as 100 per cent later than in animals given the same amount of streptomycin.

Cat treated with streptomycin shows no nystagmus after whirling.		On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*.				
		Streptomycin		<i>Vestibular damage % of patients</i>		
		Dihydrostreptomycin		<i>Mild</i>	<i>Moderate</i>	<i>Total</i>
		Distrycin		12	6	18
		Streptomycin		6	0	6
		Dihydrostreptomycin		0	0	0
		Distrycin		0	0	0
Cat given the same amount of Distrycin has normal reflex.		Streptomycin		<i>Cochlear damage % of patients</i>		
		Dihydrostreptomycin		<i>Mild</i>	<i>Moderate</i>	<i>Total</i>
		Distrycin		0	0	0
		Streptomycin		0	0	0
		Dihydrostreptomycin		12	3	15
		Distrycin		0	0	0

\*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

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# News from the County Societies

Dr. O. T. Kidder and his staff at Irene Byron Hospital, Fort Wayne, were hosts at the first dinner meeting of the season of the **Fort Wayne (Allen County) Medical Society**. The meeting was held at the hospital on September 7.

Dr. John V. Thompson, Indianapolis thoracic surgeon, was the main speaker. His paper was "Traumatic Rupture of the Trachea and Bronchi".

**Bartholomew-Brown County Medical Society** members held a dinner meeting September 8 in the Harrison Lake Country Club with 25 members present. A general business meeting followed during which they discussed medical forums, a school inoculation project and approved a survey made by the Heart Foundation. Robert J. Amick, ISMA field secretary, spoke briefly on organization matters.

Dr. Marion Hochhalter, Logansport, spoke of her recent travels in Europe at the October 18 meeting of **Cass County Medical Society**. Thirty members and wives attended the dinner meeting in St. Joseph's Hospital, Logansport. A brief routine business meeting was held. The next meeting was to be held November 15 in Memorial Hospital, Logansport, at 6:30 p.m.

The **Elkhart County Medical Society** met October 7 in the Hotel Elkhart for a dinner meeting and talk by Lt. Commdr. L. P. Eisman,

United States Navy. He discussed "The Biological, Chemical and Radiological Aspects of Modern Warfare."

"Care of the Premature Infant" was discussed by Dr. Charles Warner, Evansville, before 11 members of the **Gibson County Medical Society** at the meeting September 8 in the Hotel Emerson, Princeton. A business meeting followed the dinner.

The October 13 meeting was also held in Hotel Emerson with Dr. James O. Conklin, Terre Haute, as the guest speaker. He presented a paper on "Management of Thyroid Disease" to 11 members.

Reports were also made of the April, May and June meetings, all of which were held in Princeton. The April 14 speaker was Dr. Eugene L. Hendershot, Evansville, whose paper was "Common Pitfalls in X-Ray Diagnosis"; May 12 speaker was Dr. William Harry Howard, Hammond, president of the Indiana State Medical Association who spoke on "Your State Medical Association"; "Office Gynecology" was discussed by Dr. Owen L. Slaughter, Evansville, at the June 9 meeting.

"Clinical Pathology" was the subject of a paper presented by Dr. R. D. Solomon, Terre Haute, at the September 16 meeting of the **Greene County Medical Society**. Fifteen members attended the meeting in the Freeman Greene County Hospital at Linton.

The **Hancock County Medical Society** and Auxiliary held a joint dinner meeting September 27 in the Hancock County Hospital with 26 members present. Separate business meetings were held. The society discussed several professional matters and then heard a tape recording on "The Use and Abuse of Antibiotics" by Dr. W. E. Herrell, Lexington, Kentucky. R. J. Amick, field representative, discussed the annual convention and various services available through ISMA headquarters.

(Continued on Page 1344)

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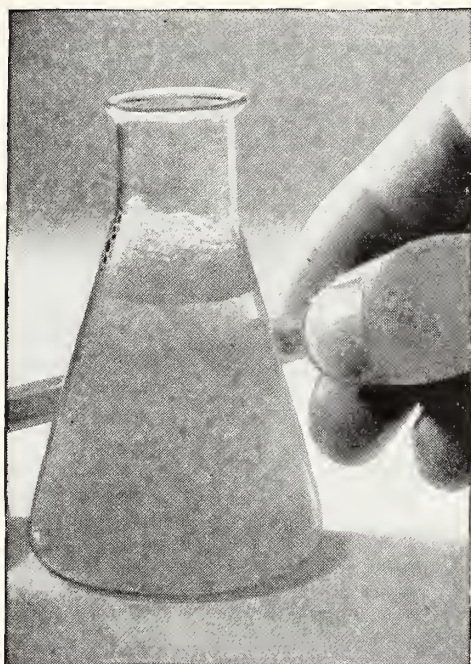
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1. American Medical Association: *New and Nonofficial Remedies*, 1954. J. B. Lippincott Co., Philadelphia, p. 147
2. Scott, R. L., and others: *Antibiot. & Chemo.* 4:691 (June) 1954



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Dr. Pasquale Genovese, Indianapolis, spoke on "Common Cardiac Diseases Amenable to Surgery" at the September 23 meeting of **Henry County Medical Society**. Twenty-eight members attended the evening meeting held at 8:30 o'clock in the Henry County Hospital, New Castle.

**Howard County Medical Society** members held their first meeting of the fall season September 7 in the Francis Hotel in Kokomo. Dinner was served at 6:30 o'clock to 26 members. A business meeting followed.

Twenty-one members of **Knox County Medical Society** held a business meeting September 21 in the Grand Hotel, Vincennes, following 6:30 dinner. They discussed emergency call service and other local programs and voted to omit making a nomination for the "Physician of the Year" award. Their nominee won the 1953 award.

At the October 19 meeting of the society Robert J. Amick, ISMA field secretary for southern Indiana, spoke following the dinner in the Grand Hotel. He outlined plans for the 1954 annual convention and discussed the availability of tape recordings and other services

of the state headquarters office. The resolutions which will come before the House of Delegates were read to the 19 members present.

Dr. James R. Webster, dermatologist on the staff of Northwestern University Medical School, Chicago, spoke on "Lues" to 35 members of **LaPorte County Medical Society** September 16 at a dinner meeting in the Kingsbury Ordnance Plant.

At a business meeting the group approved Blue Shield's proposal to hold a conference for doctors' assistants. The LaPorte County Society will be host to the 13th District meeting November 17 at Norman Beatty Hospital, Westville.

The October 21 meeting was held in Willard's Sea Food restaurant in Michigan City with Dr. Robert Ritter, professor of bone and joint surgery at Loyola Medical School, speaking on "Benign Bone Tumors."

**Madison County Medical Society** members held a dinner meeting September 18 in the Anderson Country Club with 38 physicians attending. Dr. Palmer Eicher, Indianapolis, presented a paper on "Low Back Pain".

New members welcomed were Dr. Alvin Bridges, Anderson; Dr. Roscoe A. Lanning, Elwood, and Dr. Robert P. Ulrey, Elwood. Both Dr. Lanning and Dr. Ulrey transferred from Indianapolis Medical Society. It was also announced that Dr. Marion Drake, Elwood, had entered military service in July.

Dr. M. E. Castle, Detroit, Michigan, was the guest speaker at the October 18 meeting, also held in the Anderson Country Club. He spoke on "Gait Problems in Children". Two new members, Dr. John T. Kiely and Dr. C. Richard Bowers, Anderson, were welcomed by the 43 members present.

The November 15 meeting was scheduled for 6:30 p.m. in the Anderson Country Club.

Dr. Frank W. Peyton, Lafayette, addressed members of the **Montgomery County Medical Society** September 16 at a dinner meeting in Culver Union Hospital, Crawfordsville. He spoke on "Sterility: the weak links in the chain of events leading to pregnancy." Dr. Frank D. Johnson, Waynetown, presided at the business meeting when the 35 members attending voted

(Continued on Page 1346)



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to cooperate in planning a workshop for doctors' assistants under the sponsorship of the Blue Shield; welcomed Dr. Richard Eggers into membership, and discussed several routine matters.

**Morgan County Medical Society** met at Martinsville Mineral Springs at Martinsville September 26 for a dinner meeting with the Auxiliary. Separate business meetings were then held. Six physicians heard a tape recording on "Use and Abuse of Antibiotics" by Dr. W. E. Harrell, Lexington, Kentucky and a discussion by the field secretary on the annual convention and services of ISMA.

Dinner in the Bloomington Country Club September 20 was followed by a lengthy business meeting of 33 members of the **Owen-Monroe County Medical Society**. L. E. Converse explained the changes in the Blue Cross-Blue Shield plans and R. J. Amick gave a report on plans for the state convention and outlined services available from headquarters, emphasizing the library of recordings which are available for use by societies and individual members.

**Perry County Medical Society** met September 7 in the Perry County Nurse's office in Cannelton with nine members present. They discussed welfare services, insurance and other matters of general interest and then joined in a discussion led by Dr. Donald L. Lashley, Tell City, on the drug of choice in treating many of the acute infections.

R. J. Amick, field secretary, was present and

answered numerous questions regarding association services.

Dr. Donald J. White, Indianapolis, was the guest speaker for the **Shelby County Medical Society** meeting September 8 in the W. S. Major Hospital, Shelbyville. He spoke on "Allergy as It Relates to General Practice." Fourteen members were present and at the business meeting approved the classes sponsored by the Indiana Heart Association, and discussed the polio situation.

**Tippecanoe County Medical Society** members met September 14 in the 40 and 8 clubhouse, Lafayette, with 42 members and 1 guest present. A general business meeting was held during which Dr. W. J. Pierce, who transferred from the Indianapolis Medical Society, was voted into membership; he will practice in Brookston. Approval was given for a Blue Shield workshop for office assistants.

Dr. W. W. Washburn discussed the program being worked out between the civil defense organization and the disaster committee of the county society. Chairmen of three committees to work on the project were named. They are: Field committee, Dr. R. R. Hughes; St. Elizabeth committee, Dr. Edward Stahl; Home Hospital committee, Dr. W. B. Ferguson. Dr. Washburn was authorized to complete organization arrangements.

**Vanderburgh County Medical Society** members enjoyed a barbecue in the grove at Evansville State Hospital September 14. Dr. Milton Anderson, host, was also the speaker at

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the first meeting of the fall season. He discussed "Recent Developments at the State Hospital" after which a business meeting was held.

On October 12, the society was entertained by the Board of Managers and Dr. Joseph Moody, superintendent, of Boehne Hospital at a dinner meeting at the hospital. Dr. John Mahaffy, director of the Vanderburgh County Child Guidance Center, spoke on "What Is Psychotherapy?" He also showed a film "Angry Child."

The Vanderburgh County society has moved into new quarters at 205-206 Wright Building, 109½ S. E. Third Street, Evansville.



Pictured together at a late spring meeting of Carroll County Medical Society are Dr. James R. McLaughlin, Flora, president; Dr. Max R. Adams, also of Flora; and Dr. John R. Wagoner, Delphi.

Seven outstanding speakers were on the program for the Eighth Annual Fall Clinical Conference sponsored by the **Wells County Medical Society**. The one-day session was held in the Bluffton Country Club on October 13.

Speakers and their topics were: Dr. Harrison Evans, associate professor of psychiatry and associate professor of medicine at Ohio State University School of Medicine, who also is co-director of the Harding Sanitarium at Worthington, Ohio, "The Management of the Psychiatric Patient in General Practice"; Dr. Harold Perry, section of dermatology, the Mayo Clinic, Rochester, Minnesota, "Dermatology in the Practice of General Medicine"; Dr. Marlow Manion, professor of otolaryngology, Indiana University School of Medicine, "Tracheotomy in Lower Respiratory Obstruction"; Dr. Richard H. Chamberlain, department of radiology, University of Pennsylvania, Philadelphia, "Radioactive Isotopes in Clinical Practice"; Dr. Walter A. Keitzer, Akron, Ohio, "Treatment of Acute Uremia and Artificial Kidney Dialysis"; and Dr. Irvine H. Page, director, Cleveland Clinic, Cleveland, and president-elect of the American Heart Association, "The Treatment of Hypertension."

At the 6:30 dinner in the clubhouse, Dr. Claude S. Black, past president of the state association, substituted for Dr. Wm. Harry Howard, Hammond, 1953-54 president, who was unable to attend. Dr. Maurice E. Glock, District Councilor, also spoke at the dinner.

Eighty-five physicians from the northeastern part of the state attended. Officers of the Wells County Medical Society who arranged the event were Dr. Homer Annis, president; Dr. Jack L. Eisaman, vice-president; and Dr. Richard P. Yoder, secretary-treasurer.

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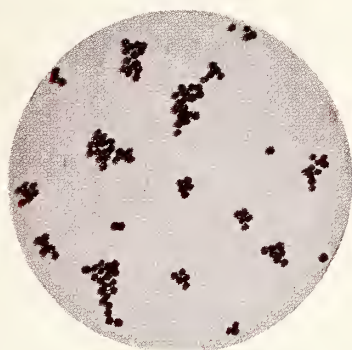
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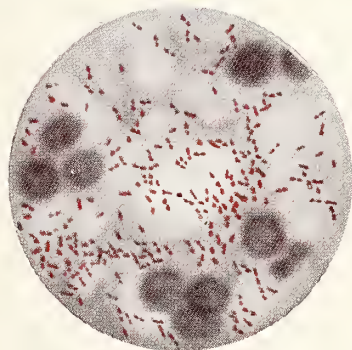
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# The *Journal*

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## Pheochromocytoma:

### CASE REPORT OF DIAGNOSIS AND SURGICAL CURE

GEORGE T. LUKEMEYER, M.D.\*

*Indianapolis*

**T**HE HYPERTENSIVE VASCULAR DISEASES constitute one of the major frontiers of medicine. Pheochromocytomas are an infrequently encountered cause for hypertension. A surprisingly large and rapidly growing literature on the subject accentuates the disparity with which pheochromocytomas occur. Nevertheless, pheochromocytoma is probably the commonest surgically curable hypertensive disorder. The physician is obligated to make an early accurate diagnosis in the hope that a surgical cure can be forthcoming.

In 1886, Frankel<sup>1</sup> reported on bilateral adrenal tumors in an 18 year old woman who had suffered paroxysmal attacks of headache, vomiting and pallor. The patient died suddenly and the autopsy disclosed adrenal tumors and cardiac hypertrophy. Thirty-six years later a Parisian surgeon, Maurice Labbe, observed and described a syndrome of paroxysmal hypertension in a 28 year old woman. The postmortem examination revealed a pheochromocytoma in the left adrenal.

Vaquez and Donzelot made the first correct antemortem diagnosis in 1924. Their patient refused surgery and two years later the diagnosis was confirmed by autopsy. Mayo in 1927 reported "... a case of paroxysmal hypertension ... because of the unusually interesting history, the difficulty attending diagnosis, and the complete and permanent relief obtained following surgical removal of a tumor which was apparently the inciting cause."<sup>2</sup> This was a left extra-adrenal tumor which the pathologist called a "retroperitoneal malignant blastoma". Two years later Pincoffs<sup>3</sup> diagnosed and successfully excised a 150 gram pheochromocytoma from the right adrenal of a 25 year old woman with paroxysmal hypertension. The histamine provocative test for pheochromocytoma was introduced in 1945 by Roth and Kvale.<sup>4</sup> A quick resurgence of interest in the disease ensued and since that time an increasing index of suspicion, the development of new pharmacological testing agents and refinements in radiological techniques has resulted in an enlarging number of diagnosed and successfully treated cases.

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\*Indiana University Medical Center.

## CASE REPORT

J. F.—Age 67. Hospital number 188348

This 67 year old white man was admitted to the private ward of the Robert W. Long Hospital on October 5, 1953 with the provisional diagnosis of pheochromocytoma. The patient was on Dr. J. O. Ritchey's service having been referred to him by Dr. Robert Edward Lyons, who had made the diagnosis of pheochromocytoma.

The patient's chief complaint was intermittent recurring "attacks" which had begun 10 years previously. A pounding, thumping, and pulsating sensation in the epigastrium would announce the onset of a typical "attack". This would be followed shortly thereafter by a somewhat similar throbbing sensation in his head. As the "attack" progressed he would develop a severe bitemporal headache accompanied by a "ringing" in his ears. At this stage in the paroxysm his wife noticed circumoral pallor and a rapidly mounting pulse rate. The "attack" having reached its greatest intensity would then subside over a variable period of time ranging from 5 to 45 minutes. The radial pulse rate would gradually slow from peak levels of 120 to normal levels of 70. Following this the patient would break out in a drenching sweat and feel quite fatigued. The attacks occurred at irregular intervals without any known precipitating factor. The patient had learned that lying on his left side would occasionally incite an "attack".

Ten years prior to admission while convalescing from an appendectomy he had sustained three typical "attacks" on each of three successive days. This was followed by a three year period during which he was asymptomatic. The "attacks" then returned and began occurring with increasing frequency and mounting severity. In April 1953 an "attack" was accompanied with hemoptysis and marked dyspnea. Frank pulmonary edema and hemoptysis complicated an "attack" on September 17, 1953.

The family history revealed that the patient's father died at age 60 of a heart attack and his mother died at about the same age of a stroke. One brother died at age 50 of a "heart attack".

*Physical examination:* On admission this man was a calm, cooperative, intelligent and good-natured white male. The point of maximal impulse was 13 cm. to the left of the mid-sternal

line in the 5th interspace. A soft systolic murmur was heard in the apical and basilar areas. Blood pressure readings were taken throughout the examination and at 7:36 p. m. the blood pressure was found to be 180/80 when he assumed the recumbent position. Eight minutes later the pressure was 130/70. At 7:45 p. m. it was found to be 156/80 and the patient was brought to the standing position and his blood pressure fell precipitously to 94/64. The patient was promptly placed in the supine position and the pressure returned to 160/80. The remainder of the physical examination was essentially non-contributory.

*Laboratory Examination:* The following studies were negative or within normal limits: urine analysis, hemogram, fasting blood sugars, CO<sub>2</sub> and EKG. One blood sugar during an attack was 161 mgm%. Preoperative B.M.R.'s were +19 and +15. Postoperative B.M.R.'s were +15 and +12. The chest x-ray revealed "... bilateral pulmonary emphysema of a moderate degree." The kidneys, ureters and bladder were normal. Intravenous pyelography demonstrated a "questionable density above the shadow of the right kidney."

*Course:* In the hospital the patient had frequent paroxysmal attacks most of which were dramatically aborted by the intravenous administration of 10 mgm of Regitine. A cold pressor and two histamine tests were performed. The results of these procedures will be discussed later. It was felt that the diagnosis of a pheochromocytoma in the region of the right adrenal had been established with reasonable certainty. On October 16, 1953 Dr. H. B. Shumacker, Jr., removed a well encapsulated tumor measuring 8 cm. in diameter from the site of the right adrenal. It was necessary to maintain the patient's blood pressure with a slow continuous levophed infusion for 24 hours postoperatively. His recovery was uneventful and he left the hospital on October 24, 1953.

Pheochromocytoma has been labeled the "great mimic" among hypertensive vascular disorders. The diagnosis is frequently difficult because of the variable clinical picture, equivocal pharmacological tests and inconclusive roentgenographic studies. The estimated incidence of pheochromocytomas among all hypertensives is variously given as 0.3% to 3%. It occurs twice as fre-



quently in the right adrenal as in the left. In approximately 10% of the reported cases the pheochromocytomas are bilateral. Neurofibromatosis has been a coexistent condition in approximately 10% of the cases in the literature.<sup>5</sup> Pheochromocytomas occur any place in the body where chromaffin tissue is found and a common extra-adrenal location is the organ of Zuckerkandl just above the bifurcation of the aorta. The sex distribution is approximately equal. "Probably less than 10 per cent of pheochromocytomas are demonstrably malignant but all that discharge hypertensive agents must be considered patho-physiologically malignant being eventually lethal."<sup>6</sup>

The clinical syndromes have been "... characterized as follows, (1) Paroxysmal hypertension (adrenal sympathetic syndrome); (2) persistent hypertension mimicking essential or malignant hypertension; (3) a combination of hypertension, hypermetabolism and glycosuria and (4) persistent hypermetabolism or hyperglycemia coexistent with intermittent hypertension."<sup>7</sup> In the reported cases the sustained type of hypertension simulating essential hypertension is as common as the paroxysmal hypertensive group.

The patient discussed in this report is a rather typical example of the paroxysmal hypertensive group. Smithwick and associates<sup>8</sup> have so handsomely described the clinical features of pheochromocytoma that it does not warrant repetition.

In the last decade a number of pharmacological testing agents have been developed and these fall into the adrenolytic and the provocative group. Regitine and Benzodioxane are the drugs currently favored among the adrenolytic group. We routinely use Regitine as a screening test in the investigation of most, but not all, hypertensives. This test can be performed promptly and safely as an office or outpatient procedure. It is important to remember that the patient must not be on sedative therapy nor in uremia when this test is undertaken. We place the patient in the recumbent position and take blood pressures at three to five minute intervals until a base line level is established. A venipuncture is then performed and several blood pressures are recorded at 30 second intervals and if the base line remains stable 5 mgm of Regitine is rapidly injected intravenously. Blood pressures and pulse rates are then taken

at 30 second intervals for 3 minutes and then at 1 minute intervals, until the base line pressures are again approximated. Similar determinations are then taken at 5 minute intervals for 15 minutes. Our criteria for a positive test is a minimum fall in blood pressure of 35 mm. Hg systolic and 20 mm Hg diastolic. In this patient spontaneous paroxysmal hypertensive attacks were repeatedly aborted on the ward by the administration of 10 mgm. of Regitine intravenously. False positive reactions are not uncommon and some investigators<sup>9</sup> report they occur in 20% of the patients tested. The high incidence of false positive reactions therefore prohibits the use of Regitine as a mass screening technique. Every positive Regitine test should be followed by a Benzodioxane test. The alarming side reactions that not infrequently develop with Benzodioxane make it imperative that this procedure be performed only on the hospitalized patient.

The provocative testing agents include histamine, tetraethylammonium chloride and mecholyl. We prefer and use the histamine test exclusively. A positive histamine test is very suggestive of pheochromocytoma as this test rarely ever gives false positive responses. It is our procedure to precede the histamine test with a cold pressor test. Our initial test is done with 0.025 mgm of histamine base injected intravenously rapidly. Blood pressure and pulse rate determinations are obtained in a manner identical to that described for the Regitine test. A negative or equivocal response to 0.025 mgm histamine base is followed by using 0.05 mgm histamine base I.V. We employ the histamine test only if the base line blood pressure is 170/90 or lower. Regitine should be available for immediate administration each time the histamine provocative test is undertaken. A positive histamine test results when there is an elevation of at least 55 mgm Hg systolic and 35 mm diastolic. The response to histamine should be, in the vast majority of instances, significantly greater than the elevation obtained with the cold pressor test. Figure one illustrates the response to the cold pressor test by our patient. The 0.025 mgm histamine response (figure two) was not unlike that obtained with the cold pressor test and hence we regarded it as an inconclusive test. A typical severe "attack" was precipitated by 0.05 mgm histamine base as depicted in figure



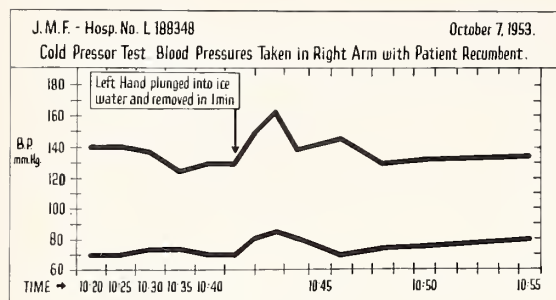


Figure 1

three. The patient's response was so alarming that we administered 10 mgm of Regitine and promptly terminated the "attack". The histamine test is a valuable procedure in the group of patients with paroxysmal hypertension.

A number of clinics are now studying urinary catecholamine excretion.<sup>7-10</sup> This is probably the most reliable single laboratory determination for detecting pheochromocytomas. In 1950 Von-Euler<sup>10</sup> studied the catecholamine excretion of six patients with pheochromocytomas. It was his interesting observation that in those patients excreting predominately increased amounts of noradrenaline that the tumors were located outside the adrenals while in those with predominately adrenalin excretion the tumors were located in the adrenals. He has since studied six additional patients with pheochromocytoma and has once again observed this same relationship.

A simple and accurate blood test for catecholamine content would be of tremendous value as a diagnostic tool. No such test is available at this time.

A variety of roentgenological studies are available and help in the localization of the tumors. The following types of procedures are used: KUB flat plate of abdomen, intravenous pyelograms, perirenal air insufflation, laminograms, aortography and various combinations of these techniques. We routinely employ the I.V.P. but do not use the perirenal air studies. When the diagnosis of pheochromocytoma is strongly suspected the patient is accompanied to the radiology department and Regitine is at hand if needed.

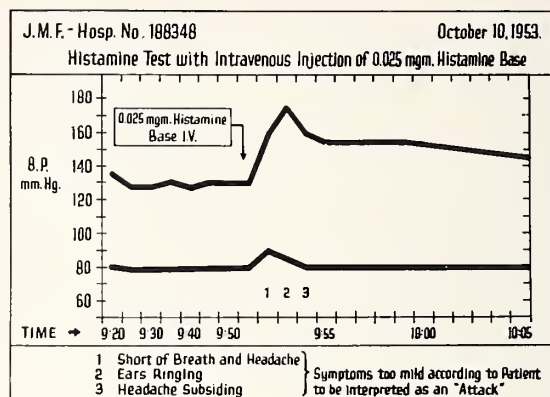


Figure 2

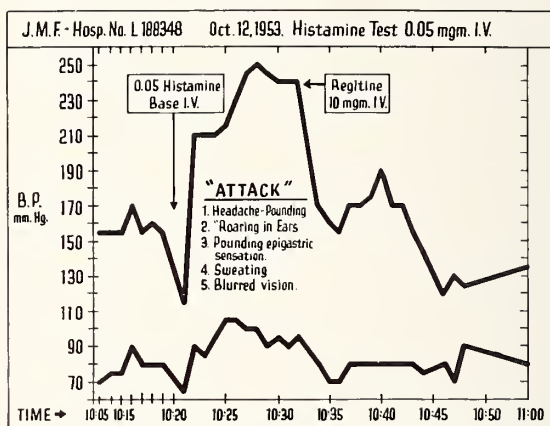


Figure 3

Surgical excision of pheochromocytomas is usually curative. This type of operation requires the close and careful cooperation of the surgeon, internist and anesthetist. The preoperative preparations, induction of anesthesia, excision of the tumor or tumors, and the immediate postoperative management demands that this team of physicians function smoothly and skillfully. The subject of this report was given the usual preoperative medication of morphine and scopolamine. Thirty minutes prior to surgery he was given 10 mgm Regitine intravenously. The patient was accompanied to the operating room by a member of the medicine department. Induction of anesthesia was begun at 7:40 a. m. utilizing pentothal sodium, nitrous oxide and anectine. An infusion with a three way stop-cock valve arrangement was started in the left upper extremity and another in the left lower

extremity. The anesthetist took blood pressure and pulse rate readings every 30 to 60 seconds. A continuous electrocardiogram was taken throughout the procedure. Through an upper abdominal transverse incision the abdomen was explored and a well encapsulated tumor mass was discovered in the right adrenal. The left adrenal was normal. The blood pressure was con-

trolled by the intermittent injection of 5 mgm of Regitine intravenously. On three occasions the blood pressure temporarily escaped control and jumped to levels of 240/140. There was a precipitous drop in blood pressure to 80/50 as soon as the tumor pedicle was clamped. We had anticipated such an event and a Levophed infusion was begun promptly and the blood pressure was easily maintained. The blood pressure and pulse rate response during surgery is summarized in figure 4. It was necessary to continue the Levophed infusion for 24 hours. The patient's blood pressure remained stable thereafter around 130/80 and his recovery was uneventful. The patient has remained asymptomatic and normotensive since leaving the hospital according to a recent communication from his physician, Robert Edward Lyons, M.D.

The tumor weighed 77 grams and measured 6 x 5.5 x 4.5 cms. It was smooth and well encapsulated with bright orange remnants of adrenal cortex on the surface as shown in figure 5A. The cut surface bulged slightly from underneath the capsule. It was a mottled pinkish gray color with small areas of mucoid degeneration as

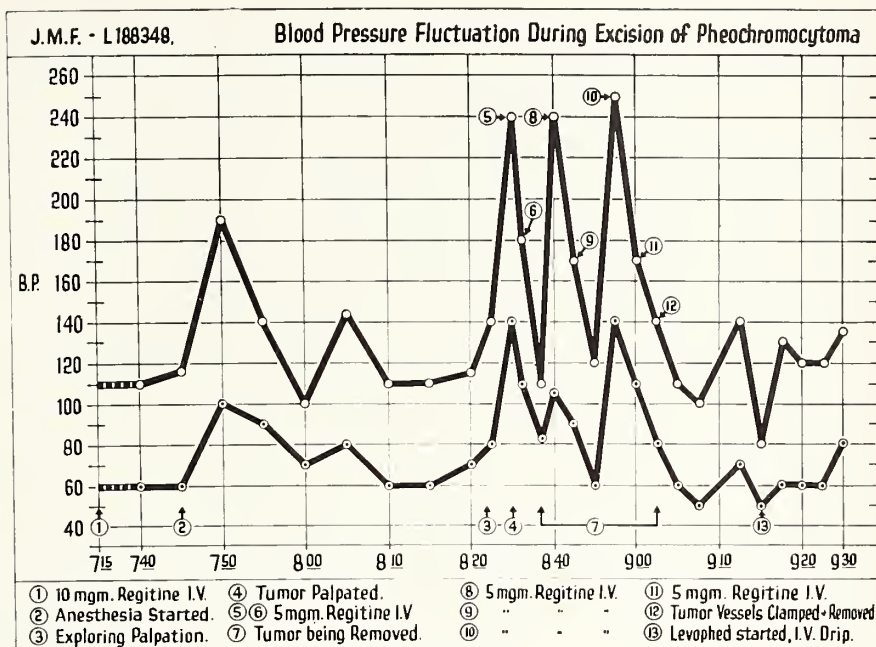


Figure 4

well as small areas of hemorrhage. (figure 5B) In the lower power photomicrograph (figure 6A) the normal cortical cells can be seen on the top and the tumor cells below. Figure 6B is a high power view of the tumor itself. One half of this tumor was frozen and submitted to Dr. K. K. Chen at the Lilly Research Laboratories, Eli Lilly and Company, Indianapolis 6, Indiana. Dr. Henry M. Lee analyzed the tumor and his report was as follows:

"One-half of this tumor was obtained for analysis for nor-epinephrine. After stripping off all cortical and capsular material the weight of the frozen tumor mass was 35.2 gms. This was ground in a Waring Blendor and then extracted with 10% trichloroacetic acid. After filtering off the precipitated protein material, a 50 cc. aliquot of this filtrate was purified by vonEuler's process (Arch. internat de pharmacodyn. 77:477, 1948). The final product from this purification was analyzed colorimetrically by the method of vonEuler and Hamberg (Acta physiol. Scandinav. 19: 74, 1949) and biologically by the method of Burn (Brit. J. Pharmacol. 5:142, 1950) for epinephrine and nor-epinephrine. A portion of this purified product was concentrated and the concentrate subjected to



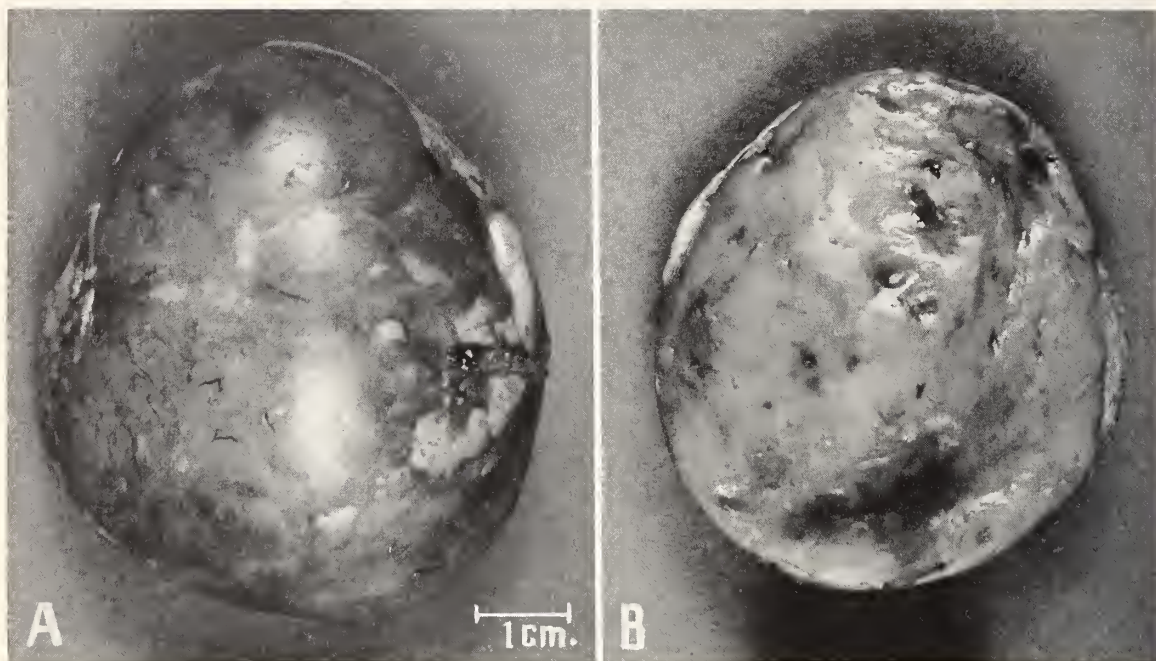


Figure 5

analysis by paper strip chromatography by Mr. Harold Bird of the Biochemistry Division.

"The results from these analyses are as follows:

1. Colorimetric test:  
 1-nor-epinephrine equivalent = 3.15 mg./gm. wet tissue  
 1-epinephrine equivalent = 1.2 mg./gm. wet tissue
2. Biological test:  
 1-nor-epinephrine = 3.0 mg./gm. wet tissue  
 1-epinephrine = 1.1 mg./gm. wet tissue
3. Paper strip chromatography: Both epinephrine and nor-epinephrine identical qualitatively.

"Normal adult adrenal glands contain on the average of 209 micrograms of epinephrine and 31 micrograms of nor-epinephrine per gm. tissue (Shepherd and West, *Brit. J. Pharmacol.* 6: 665, 1951). The ratio of nor-epinephrine to epinephrine in adrenals from children and embryonic tissue is more like that of adrenal medullary tumors with the nor-epinephrine the preponderant amine.

"In our opinion, the colorimetric test is more accurate than the biological test. The work on chromatography, of course, is for confirmation purposes. To avoid any confusion, you can very well omit the figures obtained by the biological

test although they run quite close to those of the colorimetric test."

There have been 1,035 cases of hypertensive cardiovascular disease diagnosed at the Indiana University Medical Center since 1934. This does not include any of the other forms of hypertensive disorders. In that same interval of time we have had four cases of pheochromocytoma and one pheochromoblastoma. This represents an incidence of slightly less than 0.5%. A brief review of the four other cases is given below.

#### Case 1: A. P. L3503

On January 20, 1934 a 44 year old white female was admitted to the Indiana University Medical Center complaining of severe diarrhea. She was markedly edematous and had ascites. Several blood pressure readings recorded on the chart were in the normotensive range. The patient was treated for cirrhosis but died and at autopsy an incidental finding was "bilateral paraganglioma of the adrenals."

#### Case 2: A. M. L83688 (This case was reported in the *Ann. Int. Med.* 26: 133, 1947 by Muntz, H. H.; Ritchey, J. O.; and Gatch, W. D.)

This 37 year old married, childless white female was admitted to the Indiana University Medical Center on March 27, 1951 complaining



of "the jitters" and profuse sweating. Four years prior to her admission she had had a hemithyroidectomy in an effort to control her symptoms. Adrenal massage precipitated a typical attack. The cold pressor test was positive with the blood pressure going from 130/90 to 180/120. Histamine precipitated a severe attack with the blood pressure going from 140/90 to an alarming 280/170. The I.V.P. confirmed the presence of a mass over the superior pole of the right kidney. This patient was taken to surgery but the blood pressure escaped control and vascular collapse and death ensued.

Postmortem studies disclosed this pheochromocytoma weighed 350 grams. It was analyzed by Dr. K. K. Chen and the calculated weight of adrenalin in the tumor was 2.3496 grams. Pheochromocytomas were found in the left suprarenal and there was a carcinoma of the left lobe of the thyroid with metastasis to cervical and paratracheal nodes.

### Case 3: R. J. F. R155236

This 7 year old white boy was admitted to the Riley Hospital on March 27, 1951 with "hypertensive cardiovascular disease" and congestive heart failure. It was learned that 5 or 6 months prior to admission he had begun wetting the bed at night, complaining of severe headaches three or four times a week, and experiencing recurrent bouts of profuse sweating, profound dyspnea, cyanosis and vomiting. There had been a 20 pound weight loss in that same period. The physical examination revealed a retinopathy with papilledema, exudates, hemorrhages, arteriolar narrowing and venous engorgement. There were rales in both bases, tachycardia and hepatomegaly. The blood pressures were as follows: 185/110 right arm, 190/120 left arm, 220/120 right leg, and 220/130 in the left leg. The pa-

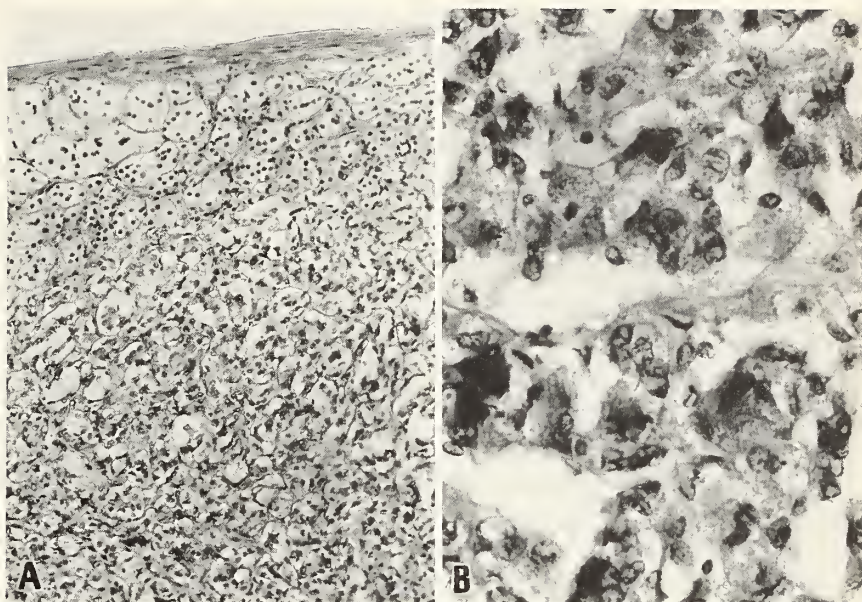


Figure 6

tient was treated for congestive heart failure with salt restriction, diuretics, and digitalization. There was some improvement but the blood pressure was constantly elevated. On April 4, 1951 a Benodaine test was performed and the blood pressure fell from 180/135 to 130/80. An I.V.P. and EKG were normal. On April 10, 1951 the patient was taken to surgery and through an upper transverse incision the adrenal glands were explored and a 4.5 gram pheochromocytoma was excised from the right adrenal. Following the excision of the tumor there was cardiac arrest requiring cardiac massage. The patient did not recover consciousness until April 16, 1951. He had a residual weakness of the left side of the body and an associated expressive aphasia when he left the hospital. His blood pressure returned to normotensive levels following surgery.

### Case 4: G. W. H. L193149

This 49 year old white male was admitted on January 30, 1954 in a semicomatose condition with a right hemiplegia. The history obtained from the wife was that the patient had had headaches for 8 or 10 years prior to admission. She specifically denied any knowledge of hypertension. Two weeks prior to admission the patient had sustained a sudden paroxysm of coughing and retching. He either vomited or coughed up a small amount of blood at that time. This was followed by the gradual development of a right

hemiparesis and loss of consciousness. The physical examination revealed a blood pressure of 146/90, bilateral papilledema, lateral nystagmus and right hemiplegia. He was cared for on the neurosurgical service and in spite of careful treatment died on February 22, 1954. The autopsy revealed bilateral pheochromoblastoma with metastasis to the brain.

### Summary:

(1) We have presented the case of a 67 year old man with paroxysmal hypertension in whom a diagnosis of pheochromocytoma was made on the basis of his clinical findings and confirmed by a positive response to Regitine and a positive histamine provocative test.

(2) Surgical excision was curative and the need for a team of skillful physicians cooperating fully has been stressed.

(3) We use the Regitine test as a screening procedure in most, but not all, cases of hypertension. A positive Regitine test should be followed by a Benzodioxane test.

(4) In the paroxysmal hypertensive patients we utilize the intravenous histamine test.

(5) Pheochromocytoma has been encountered in four patients and a pheochromoblastoma in one patient since 1934. Three of the pheochromocytomas were physiologically active producing "hypertension". There have been 1,035 cases of hypertensive cardiovascular disease in that same interval of time.

Acknowledgement: The author would like to thank Robert E. Lyons, M.D. and J. O. Ritchey, M.D. for granting him the pleasure of making this case report.

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Indianapolis, Indiana

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# Prolonged Labor\*

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**P**ROLONGED LABOR puts more than the usual strain upon the attendant. The outcome of any labor is not certain, and when it is long delayed even an obstetrician of unusual skill and judgment must be disturbed, to say nothing of the anxiety of the parturient and her family. It predisposes to postpartum hemorrhage, increases maternal morbidity, and exacts its toll in fetal mortality. These are some of the reasons why prolonged labor should be recognized as a clinical entity worthy of serious consideration.

There is no generally accepted definition of prolonged labor, variations in the upper limit of normal ranging between 18 and 48 hours. Most authors agree that active labor for more than 24 hours is prolonged. Since its average length in a primipara is 18 hours, the 24 hour limit seems reasonable. Accurate determination of its length depends upon recognition when labor begins. Not uncommonly preliminary pains occur for a day or two before the actual onset of labor, and should not be considered as part of the duration. True labor begins with the contractions that bring about progressive effacement and dilatation of the cervix. The question is not one of time alone. More than minimum labor in the presence of an insuperable obstacle to delivery is too long, whereas 48 hours or more of mild and infrequent pains until near the end may constitute an easy birth. Only exceptionally should labor be allowed to continue over 72 hours.

The frequency of prolonged labor in reports in the literature varies, since its definition is not uniform. Its incidence, in general, averages between 3 and 4 per cent. About 75 percent of cases occur with the first pregnancy.

Except where there is gross neglect the prolongation of labor invariably is in the first stage, and usually is the result of faulty and ineffective

uterine contractions. Cephalopelvic disproportion, and malpresentation and malposition, especially breech presentation, are commonly associated with a prolonged first stage, but in these situations ineffective uterine action is the real cause of the delay. Why this association occurs has never been satisfactorily explained. Constriction ring dystocia, rarely seen, is considered by Eastman<sup>1</sup> a form of uterine inertia.

The cause of uterine inertia is not clear. As is well known, precipitate labor may occur in a subsequent pregnancy. Under normal or favorable circumstances the uterine contractions of labor are properly coordinated, with contraction of the active portion and relaxation of the passive segment of the organ. In an effective labor the contractions begin simultaneously in the uterine cornua, and spread evenly over the uterus. They occur at regular, gradually diminishing intervals, with gradually increasing intensity and duration. In order that this coordinated activity may occur, the uterine muscle must be in what Danforth<sup>2</sup> calls that "nebulous state of affairs referred to as proper nutrition."

According to Eastman<sup>1</sup> uterine inertia may be attributed to one of three causes: faulty development or diseased conditions of the uterine musculature, anomalies in its innervation, or mechanical interference with its contraction. The first factor may be associated with imperfect general development with contracted pelvis, but may occur in apparently normal women. It may be attributable to loss of tone incident to excessive distention from hydramnios or multiple pregnancy, or to intrapartum infection which may in some way directly affect the muscle.

## ROLE OF THE EMOTIONS

With reference to the second cause, we know that the nerve supply of the uterus is derived from both the sympathetic and parasympathetic

\*Read at the 1953 annual convention of the Indiana State Medical Association.



systems, and that their action is generally antagonistic. The neuro-muscular mechanism involved is obscure, and the existence of abnormalities in the innervation of the uterine muscle can not be proved directly. However, it is common clinical experience that fear, tension, or pain may interfere with normal uterine motility. This fact, known to earlier obstetricians, has been emphasized in recent years by Grantly Dick Read,<sup>3</sup> but it seems to me that he has developed his thesis to an extreme view. Certainly there are exceptions. I recall a primigravida who showed such anxiety and lack of confidence that I suggested she seek care elsewhere. In spite of this she retained me, and delivered a nine pound baby after two hours of labor. This is not told to discount the fact that there is an emotional labor which is as definite and important as its physical counterpart. As Eastman<sup>1</sup> says, the very presence of a friendly doctor and the realization that he is competent to handle any emergency is in itself the safest and most welcome of obstetric anodynes. Physiological processes such as digestion and cardiac action go on more smoothly in the absence of emotional tension, and it seems reasonable that this would hold true for the functioning of the uterus in parturition. To show earlier obstetricians appreciated this fact I quote from a letter to Simpson by Meigs<sup>4</sup> written on February 18, 1848: "I have found that women, provided they are sustained by cheerful counsel and promises, and carefully freed from the distressing element of terror, could in general be made to endure, without great complaint, those labor pains which the friends of anesthesia desire so earnestly to abolish and nullify for all the fair daughters of Eve."

An additional common cause of uterine inertia is the premature administration of analgesic drugs.

Mechanical factors that may interfere with effective uterine action are myomata, adhesions, and pelvic inflammation. In my experience non-obstructing fibroids have caused no difficulty.

It may be concluded that uterine inertia, like proper nutrition of the uterine muscle, is a nebulous state so far as etiology is concerned.

At times prolongation of labor is attributed to a rigid cervix. This may be true in an elderly primipara in whose cervix the fibrous tissue predominates, but the fault usually lies in poor uterine contractions. High amputation of the

cervix, scarring from disease or too generous cauterization, and carcinomatous infiltration may retard or prevent dilatation.

A condition occasionally seen is conglutination of the external os<sup>5</sup> or cervical canal. Here there may be hard pains but no progress until the small cervical opening, usually found with difficulty on vaginal examination, is gently enlarged by pressure with the examining finger. I recall several cases in which this was found and corrected by vaginal examination done to determine the cause of the lack of progress, and in which dilatation then proceeded rapidly. The same holds for adherent membranes whose impeding effect may be overcome by stripping or artificial rupture.

All authorities are agreed that prolonged labor results in increased maternal morbidity and fetal mortality. Some of this may be due to ill-advised operations to effect delivery, or to the injudicious use of posterior pituitary solution. The relationship holds true, however, in properly managed cases. Thus Schmitz,<sup>6</sup> in an analysis of 11,646 labors, 363 of which were prolonged, found maternal morbidity and fetal mortality 3.2 per cent and 3.2 per cent respectively in the total group as compared with 12.4 per cent and 7.9 per cent in the prolonged group. In Starr's<sup>7</sup> series of 404 prolonged labors in 7,989 deliveries, maternal morbidity was 18 per cent as against 2.4 per cent incidence for all deliveries. Fetal mortality was 7.4 per cent as against 3 per cent. Eastman<sup>1</sup> points out that labors which last more than 24 hours, particularly if the membranes have been ruptured through most of the period, provide bacteria with readier and more prolonged access to the uterus. Such cases may be terminated by difficult operative measures. Furthermore, the sluggish activity of the uterus may continue into the third stage, resulting in atonic bleeding. The resulting triad of exhaustion, hemorrhage, and infection is responsible for the figures reported by Schmitz and Starr.

Mengert<sup>8</sup> states that fetal dangers stem chiefly from anoxia and infection. According to him the fetus tends to die in utero toward the end of a prolonged labor. Its oxygen supply is diminished from failure of the uterus to relax completely between contractions. Infection may reach the fetal circulation through the vessels on the fetal surface of the placenta, or amniotic fluid teeming with bacteria may enter the fetal

lungs. Trauma incident to difficult delivery must not be disregarded.

### IS THIS TRUE LABOR?

Before any type of therapy is considered, it must be established that the patient is in true labor as evidenced by progressive effacement and dilatation of the cervix. Efforts to stimulate false labor are futile, painful and exhausting for the patient, and confusing to the attendant. I have been called to see a few patients with reference to operative termination of supposed labor when all that was needed was cessation of stimulation and the administration of a sedative.

When active labor lasts 18 hours without immediate prospect of delivery, the patient should be carefully re-evaluated in order to rule out obstruction. If delivery from below can not be reasonably anticipated, cesarean section should be performed without further delay. If labor is allowed to continue, the patient and her family should be encouraged with a statement of the situation and assurance of a happy outcome. Meanwhile she should be safeguarded from infection, relieved of suffering, and provided with adequate fluid and nutrients. In most patients 12 to 18 hours are sufficient to demonstrate the capacity of the pelvis and the adequacy of uterine action. If the membranes rupture prematurely, the decision to do a cesarean should not be postponed beyond 24 hours because of the increased danger of infection.

When the presence of disproportion or obstructing tumor has been ruled out, the additional length of labor necessary for delivery may be regarded with equanimity. More and more evidence is accumulating that the antibiotics and sulfadiazine make intraperitoneal cesarean section relatively safe<sup>9</sup> after longer periods of time have elapsed or after an unsuccessful attempt at forceps delivery. This is heartening to anyone practicing obstetrics since, even with good management, abdominal delivery occasionally becomes necessary under conditions that formerly made the prognosis extremely grave. Not many years ago delivery through the birth canal was the prime objective. Long labors and difficult, often traumatic, procedures were justified by the increased likelihood of survival offered the mother. The safety of cesarean section today will naturally extend its indication in prolonged labor. Of importance in this connection is the

occasional woman who is emotionally and constitutionally unable to withstand a prolonged labor.

Now and then a labor complicated by intra-partum infection comes to a standstill with the head deeply engaged and with the half dilated cervix offering the only obstacle to delivery. Under these circumstances incision of the cervix followed by forceps delivery is the procedure of choice.

I have discussed cesarean section and incision of the cervix first although they represent the last thing that is done in prolonged labor, and really constitute failure of antecedent treatment. Incision of the cervix is rarely necessary, and cesarean section will be infrequent since with careful evaluation of the case and the exercise of good judgment it will be done, when indicated, before the labor has become prolonged.

When labor becomes unduly protracted, it is extremely important that the parturient be sustained and supported by one or more periods of rest, and adequate fluid and nourishment. Morphine, Demerol, or Pantopon, alone, or with a barbiturate or scopolamine, should be given in sufficient amount to provide complete rest for 8 hours in 24. Food should be given, but it must be light and easily digestible since during labor the emptying of the stomach is delayed and digestion is impaired. It may be necessary to supplement oral feeding with intravenous glucose. In addition to providing a readily assimilable source of energy, the glucose may, by direct action on the uterine musculature, improve the quality of the contractions. Fluid adequate to keep the urine acetone free should be given orally or parenterally. Oral fluid or food should, of course, be withheld for six hours before delivery is anticipated if an inhalation anesthetic is to be used.

Precautions against infection should be maintained. Prophylactic antibiotic therapy should be given if cesarean section is considered a possibility. Otherwise I am inclined to omit penicillin unless evidence of infection develops.

Overdistention of the bladder should be avoided, and the lower bowel should be cleared with a daily enema.

Stripping of adherent membranes from the cervix and lower pole of the uterus may have a salutary effect in desultory labor. It may be done if cervical dilatation is less than 5 cm. With 5 cm. or more dilatation and a bag of



waters in front of the head preventing it from making contact against the cervix, artificial rupture of the membranes may effectively stimulate pains.

### MEANS OF STIMULATION

With slow progress one naturally thinks of means of stimulating uterine contractions. Ambulation is considered by some to be of benefit. This, in moderation, may be helpful, but the fatigue incident to walking the halls of a hospital in an effort to bring on effective pains is poor preparation for labor. Spending this time at home with ordinary activity and rest seems more sensible.

The effectiveness of a warm soapsuds enema, given to coincide with the end of a rest period, should not be overlooked.

Quinine in small dosage (3 grains) may be helpful, but is of doubtful value and is little used.

Schmitz and Danforth use 10 cc. of calcium gluconate intravenously at intervals of four to six hours to enhance the efficiency of the myoneural junction and stimulate uterine contractions.

Although the use before delivery of posterior pituitary solution is dangerous, it is being recognized that its judicious administration is less hazardous than the maternal exhaustion, intra-partum infection, and traumatic operative delivery it is intended to prevent. Pitocin is preferable since it is more purely oxytocic and eliminates dangers of blood pressure elevation. Certain conditions must exist before its use is considered. The case must be one of true inertia, that is, failure of progress for eight hours, with the cervix 5 cm. or more dilated and with a uterus which may easily be indented at the height of a pain. Preferably the membranes should have been ruptured since this simple measure may make the use of Pitocin unnecessary. There must be no mechanical obstruction to easy delivery. Extreme caution must be used in patients of great parity and in those with overdistention of the uterus from twins or a large baby.

If given in isolated dosage, the first dose should not exceed 0.25 minim intramuscularly. If within 30 minutes there is little or no effect, the dosage may be increased to 0.5 minim, and then to 1 minim depending on results. No more

than six injections should be given, the dosage must not exceed 1 minim, and an interval of at least 30 minutes must intervene between injections. Ether should be at hand to control possible tetanic contraction of the uterus or tumultuous pains.

Although no more effective, a more physiologic method of administering Pitocin, safer and more easily controlled, is the intravenous drip technic. With this procedure 0.25 minim of Pitocin in 50 cc. 5% glucose solution (5 minims Pitocin in 1000 cc. 5% glucose) may be given in the first half hour, and increased to 0.5 minim Pitocin in the same dilution in the second half hour depending on results. This rate of infusion should not be exceeded. The Pitocin should be added to the glucose solution after the intravenous drip has been established at the proper rate in order to avoid initial overdosage. The patient should not be left unattended.

If no benefit results after three hours of its intermittent or continuous administration, Pitocin should be abandoned. Experience has shown that persistence beyond that limit is futile. Larger doses must not be given. They probably will be ineffective, but may be extremely dangerous. If delivery at that point is indicated, Dührssen's method of incision of the cervix and forceps extraction may be done if the cervix is at least 6 cm. dilated and the head engaged. If the head is high, the cervix less than 6 cm. dilated, and the child alive, abdominal delivery should be carried out.

Delay in the second stage should not be permitted to contribute importantly to the length of labor. If delay is due to failure of cooperation resulting from excessive pain, appropriate analgesia should be provided. If due to inertia, with the uterine wall easily indentable at the height of each pain and with no rotation or descent over a period of two hours, Pitocin by one of the methods already outlined may be tried, or forceps delivery done. In case of pelvic arrest, the labor should be terminated after no more than two hours of efficient second stage pains because of the danger of pathologic retraction ring or uterine rupture. If vaginal delivery is not feasible, cesarean section should be proceeded with immediately.

The conduct of the third stage in prolonged labor is of extreme importance. The abnormal



uterine physiology may extend into this stage, and result in atonic bleeding. Preparation for this complication should be made.

### SUMMARY

1. Labor lasts more than 24 hours in between 3 and 4 per cent of cases.

2. Prolonged labor is due mainly to faulty activity of the uterine musculature.

3. Fetal mortality and maternal morbidity are increased in prolonged labor.

4. Management to avoid prolonged labor or to reduce its duration is outlined.

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### AHA RESEARCH COMMITTEE ON HEART SEMINAR PANELS

The American Heart Association's Research Committee will meet in Indianapolis January 19-22 to study applications from research investigators for financial grants from AHA.

Dr. Kenneth G. Kohlstedt, past president, Indiana Heart Foundation, said that while the group is in Indianapolis, members will serve on three panels which will feature the annual Heart Seminar at Indiana University Medical Center.

These panels will be devoted to hypertension, arteriosclerosis and rheumatic fever. The sessions will begin at 3:00 p.m. in the Medical School Auditorium on January 20.

AHA Research Committee members are Howard B. Sprague, M.D., Brookline, Mass.; Charles A. R. Conner, M.D., New York, N. Y.; A. C. Corcoran, M.D., Cleveland; John C. Jones, M.D., Los Angeles; Francis Wood, M.D., Philadelphia; J. M. Crismon, M.D., Stanford University; Ancel Keys, M.D., Minneapolis; Harold Green, M.D., Winston Salem, N. C.; Robert Bayley, M.D., Oklahoma City; C. H. Rammelcamp, M.D., Cleveland, and Howard Burchell, M.D., Rochester, Minn.

# Congenital Malformations Which May Produce Gastrointestinal Tract Obstruction in Infancy and Childhood\*

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**G**ASTROINTESTINAL TRACT OBSTRUCTION in the early years of life is generally due to some congenital abnormality. A number of these anomalies tend to produce symptoms of obstruction at birth while others may not become symptomatic until the passage of months and even years. Neonatal obstructions are more likely to be complete than those occurring later.

Although the diagnosis cannot, as a rule, be established with certainty on the basis of pre-operative studies, physical findings and roentgenologic examination may prove to be of great assistance in localizing the site of obstruction and, hence, in reducing the number of etiologic possibilities. They may also be helpful in evaluating the completeness of the obstruction. Barium should not be used in upper gastrointestinal studies if complete obstruction is suspected, due principally to the hazards of aspiration of vomitus containing barium. Lipiodol is a safer radiopaque media. Its use generally is indicated only in cases of partial obstruction since the gas pattern on a plain film of the abdomen usually is diagnostic of the level of obstruction in cases of complete obstruction.

Aspiration pneumonitis and disturbances in fluid and electrolyte balance are frequently encountered and often lead to death in untreated cases and in cases in which effective treatment has been delayed too long. Intestinal rupture secondary to over-distention or gangrene from

interference with intestinal blood supply may also occur. For these reasons diagnostic studies should be carried out promptly and exploration undertaken should it seem indicated. Gastrointestinal tract decompression by suction and par-enteral replacement of lost fluid and electrolytes are, to be sure, important safeguards and their role in the preparation of the patient for operation and in postoperative care cannot be overemphasized. Antibiotics and intravenous infusions of whole blood are also of value.

Due to the necessity for prompt recognition and treatment, it has seemed desirable to review the salient diagnostic and therapeutic features of the principal types of congenital gastrointestinal tract obstruction to be encountered in infancy and childhood.

## **HYPERTROPHIC PYLORIC STENOSIS**

Narrowing of the pyloric outlet of the stomach due to congenital hypertrophy of the pyloric musculature is the commonest cause of gastrointestinal obstructive symptoms in infancy. Although the embryogenesis of this anomaly remains obscure, it is of interest that it is seldom accompanied by other congenital malformations. Pyloric obstruction is not complete at birth and several weeks of traumatic edema of the pyloric mucosa from ingested food are generally required to produce symptoms.

The symptoms are those of a high gastrointestinal tract obstruction, proximal to the ampulla of Vater. Vomiting usually begins from 2 to 4 weeks following birth. It generally occurs short-

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ly after feeding and becomes progressively more severe, often becoming projectile in nature. The vomitus does not contain bile. Severe malnutrition and dehydration develop with the passage of time as the vomiting becomes more frequent and the pyloric obstruction more complete. The greatest danger, accordingly, arises from the progressive loss of fluid and electrolytes and their parenteral replacement is of great importance in the management of these patients.

Although the diagnosis cannot be made by the appearance of the patient, these infants often show signs of weight loss and dehydration. They are characteristically hungry and take their feedings with great eagerness. Approximately 80 per cent are males. At times visible peristaltic waves may be seen to course across the left epigastrium from left to right. The diagnosis is made by the palpation of a pyloric mass in the right upper quadrant. With patient and careful examination, a mass can be identified in virtually all cases of congenital pyloric stenosis. Owing to the high degree of accuracy of physical examination, the diagnosis should be established in this way rather than by "exploratory" operation. It is generally wise for a surgeon to defer operation until he is convinced of the presence of a pyloric mass. Roentgenologic studies with lipiodol may show a narrowing and elongation of the pyloric canal (Fig. 1). They are, however, seldom indicated.

The operative management of hypertrophic pyloric stenosis, following restoration of lost fluid and electrolytes, is highly satisfactory. The operation, pyloromyotomy, is performed with relative ease and in little time, the mortality is quite low and the results and long-term prognosis are excellent. The reported experiences of Fredet<sup>5</sup> and Ramstedt<sup>22</sup> established pyloromyotomy as the operation of choice. The operation is best carried out through a right subcostal muscle splitting incision just lateral to the rectus muscle. The hypertrophied pylorus is delivered into the wound and the obstruction relieved by longitudinal incision through the avascular, antero-superior border of the pylorus with blunt separation of the moderately firm pyloric musculature. Although the hypertrophied muscle tends to separate rather easily from the mucosa, permitting the mucosa to bulge out between the muscle layers, care should be taken to avoid damaging the mucosa, especially at the duodenal end.

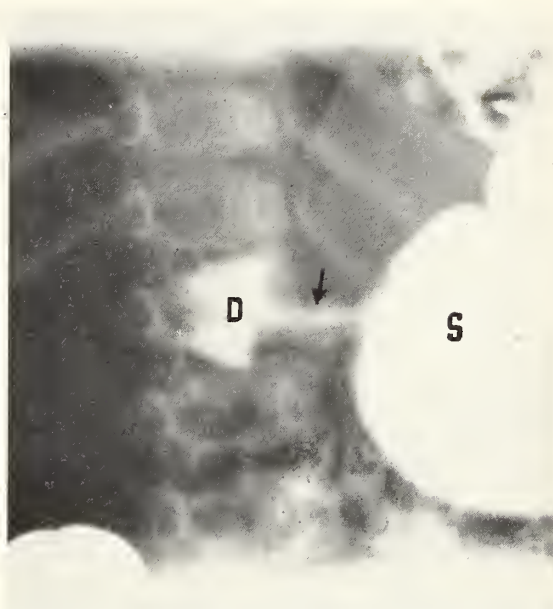


Figure 1. Roentgen study carried out upon an infant with congenital hypertrophic pyloric stenosis. The arrow indicates the elongated and narrowed pyloric canal connecting the dilated stomach (S) and the duodenum (D).

The milking of gastrointestinal gas and liquid contents past this area will facilitate the recognition and closure of small mucosal interruptions should they occur. As in other operations upon infants, it is desirable that interrupted sutures of fine silk be used throughout. The skin may be closed easily with interrupted 00000 subcuticular silk sutures and the incisional wound protected by a thin layer of collodion.

Ladd and Gross<sup>9</sup> recommended immediate postoperative feeding as soon as the infant regained consciousness. It is however, the opinion of the authors, based on experience with both methods, that better results are obtained if feeding is delayed until 24 hours following operation. There is less difficulty with vomiting and less necessity for formula cut-backs and manipulations. The withholding of oral feeding until the return of peristalsis postoperatively is a sound surgical principle, applicable to infants and children as well as to adults. The postoperative feeding of infants who have had pyloric stenosis is based on the graded transition from a simple solution, such as isotonic saline or dextrose and water, to a full nutritional formula.

#### STENOSIS AND ATRESIA OF INTESTINES

The symptoms of intestinal atresia are those of complete obstruction from birth. Those of



stenosis also tend to be of complete obstruction in approximately one-half of the cases, symptoms in the other half being more chronic and often not occurring until several weeks and even months and years after birth. The nature of the symptoms will depend, to a degree, on the level of the obstruction. Vomiting is a constant symptom and neonatal vomiting, with or without abdominal distention, should be promptly and thoroughly investigated. It is of interest that stenosis occurs most often in the duodenum (Figs. 2 and 3). Atresias may be found in the ileum and jejunum as well as the duodenum. The colon seldom is involved. Atresia is more frequent than stenosis.

The embryonic development of atresia and stenosis has generally been attributed to varying degrees of persistence of the so-called "solid" stage of fetal intestinal formation. This theory, however, fails to account for the frequent discontinuity of proximal and distal intestinal segments and mesentery.

The gas pattern on roentgenographic study of the abdomen will generally indicate the presence of obstruction and the need for operation. Farber's<sup>3</sup> test for swallowed vernix caseosa cells in the meconium may be useful in establishing the completeness of the obstruction by the presence or absence of these cells.

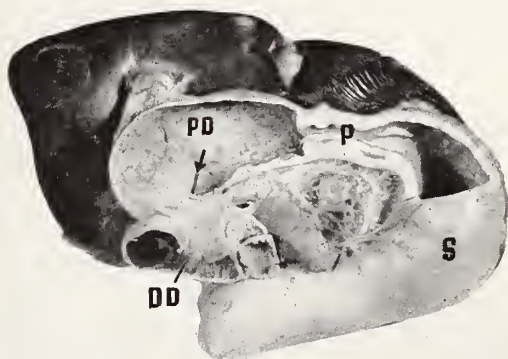
Lost fluid and electrolytes should be restored promptly and operation carried out without delay. The results from direct attack on the area of atresia or stenosis have been poor. A side-to-side by-passing enteroenterostomy is regarded as the operation of choice by most authors for the

higher lesions.<sup>19</sup> Technical difficulty often arises from the disparity in the sizes of the dilated proximal and the collapsed distal segments. Delayed recognition and treatment also have contributed to the high mortality from these malformations in the past. The recent experiences of Gross<sup>6</sup> suggest that the creation of a Mikulicz double enterostomy with early crushing of the spur is the most satisfactory method of handling ileal atresias, especially the more distal ones. Furthermore, the long-term prognosis must be guarded due to the relatively high incidence of associated anomalies. In this regard Lanman<sup>11</sup> has recently stated that 6 of 17 patients surviving operative correction of duodenal atresia were mentally retarded. Multiple atresias may occur and their management, to be sure, is considerably more hazardous than that of single atresias.

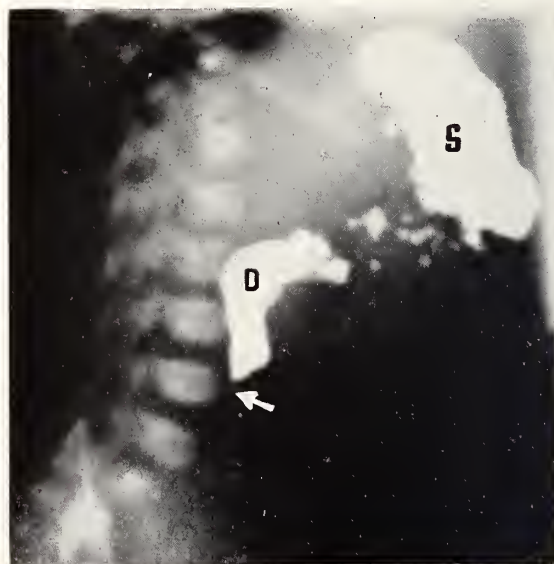
### ANNULAR PANCREAS

Annular pancreas is rare.<sup>12</sup> Its presence should be suspected in cases of duodenal obstruction, especially when the obstruction is of the second portion. In these cases the second part of the duodenum is completely surrounded by a ring of pancreatic tissue which may constrict the duodenal lumen. Although the diagnosis may occasionally be suspected from radiologic findings, it can only be established by operative identification of the pancreatic ring.

**Figure 2.** Photograph of a formalin-fixed autopsy specimen from a 6-week old infant. The arrow points toward a probe which has been passed through an area of congenital stenosis between the dilated proximal duodenum (PD) and the collapsed distal duodenum (DD).



**Figure 3.** Roentgenogram showing the level of duodenal stenosis (arrow) in a 4-week old infant. The lipiodol fills the stomach (S) and proximal duodenum (D).



The formation of an annular pancreas most likely results from faulty rotation of the dorsal and ventral pancreatic anlage. The ring is composed of normal appearing pancreatic tissue. An annular pancreas may give rise to four principal types of symptoms: duodenal obstruction, jaundice from biliary tract obstruction, pancreatitis and gastroduodenal ulceration or inflammation. Although symptoms generally are not encountered until adult life, they may occur in infancy and childhood. Neonatal symptoms are usually of acute and complete duodenal obstruction and are often associated with jaundice. It should be noted that the incidence of associated atresia or stenosis at the site of the annular pancreas is rather high in those neonatal symptomatic cases.

Many methods of relieving the duodenal obstruction have been suggested and attempted. The experience with division or partial resection of the pancreatic ring has frequently been unsatisfactory in the past. Due to the likelihood of both postoperative pancreatic fistula formation and residual duodenal obstruction, it would appear that direct attack on the obstructing pancreatic ring should be abandoned in favor of a by-pass type of operation. Duodenojejunostomy is currently regarded as the most rational operative approach.

### MALROTATION OF THE INTESTINES

Congenital obstruction may also result from faulty or incomplete rotation of the intestines. Following the tenth embryonic week the intestines, which earlier had protruded into the base of the umbilical cord, begin to recede into the abdominal cavity and, in doing so, rotate in a counter-clockwise direction. Failure to complete this normal process of rotation may result in an incompletely rotated cecum and in a short dorsal mesentery, lacking attachment along the posterior abdominal wall. In cases in which the cecum is incompletely rotated, obstruction of the second or third parts of the duodenum may occur from reflected bands of peritoneum or directly from the pressure of the overlying cecum (Fig. 4). Although symptoms tend to arise during the first weeks of life, they may not become sufficiently severe to warrant operation until months and even years have passed. The diagnosis may be strongly suspected on the basis of roentgeno-

logic studies showing the cecum in an abnormal position, especially in the right upper quadrant. Obstruction of this type may be relieved by the Ladd<sup>8</sup> operation which consists of lysis of the obstructing bands and freeing up of the cecum and the right colon, permitting them to pass over into the left side of the peritoneal cavity. Obstruction of other segments of the intestinal tract may also occur from congenital bands which presumably result from faulty peritoneal attachments. These cases may be managed satisfactorily by operative lysis of the obstructing bands.

Furthermore, the occurrence of a short or absent dorsal mesentery may predispose to a volvulus of the midgut. This volvulus is generally in a clockwise direction. The torsion may cause occlusion of the superior mesenteric vessels with potential infarction of the entire midgut and may also cause duodenojejunal junction obstruction from angulation of the structures in this area. Operative correction by derotation must be carried out early before impairment of midgut viability. It is also possible to have partial duodenal obstruction due to overlying superior mesenteric vessels. The obstruction in these cases is best relieved by a by-passing duodenojejunostomy.

### DUPLICATIONS

Congenital duplications may occur at any point along the alimentary tract. However, the majority, approximately 75 per cent, are found in the small intestine where they most frequently involve the ileum. Duplications are found in the mesentery of the intestine to which they generally are intimately adherent and with which they share a common blood supply. They are lined with alimentary tract epithelium which may or may not resemble that of the adjacent intestine and they have a coat of smooth muscle which tends to be in layers. The long tubular type of duplication usually is lined with gastric mucosa and communicates distally with the intestine causing symptoms of pain, melena and anemia from peptic ulceration. Intestinal obstruction is most often due to spherical duplications.<sup>15</sup> These seldom communicate with the intestine. Distention of the larger ones may cause obstruction from pressure on the adjoining intestine and the smaller ones may act as the leading point for an intussusception.<sup>13</sup>

Although an abdominal mass may be felt in an



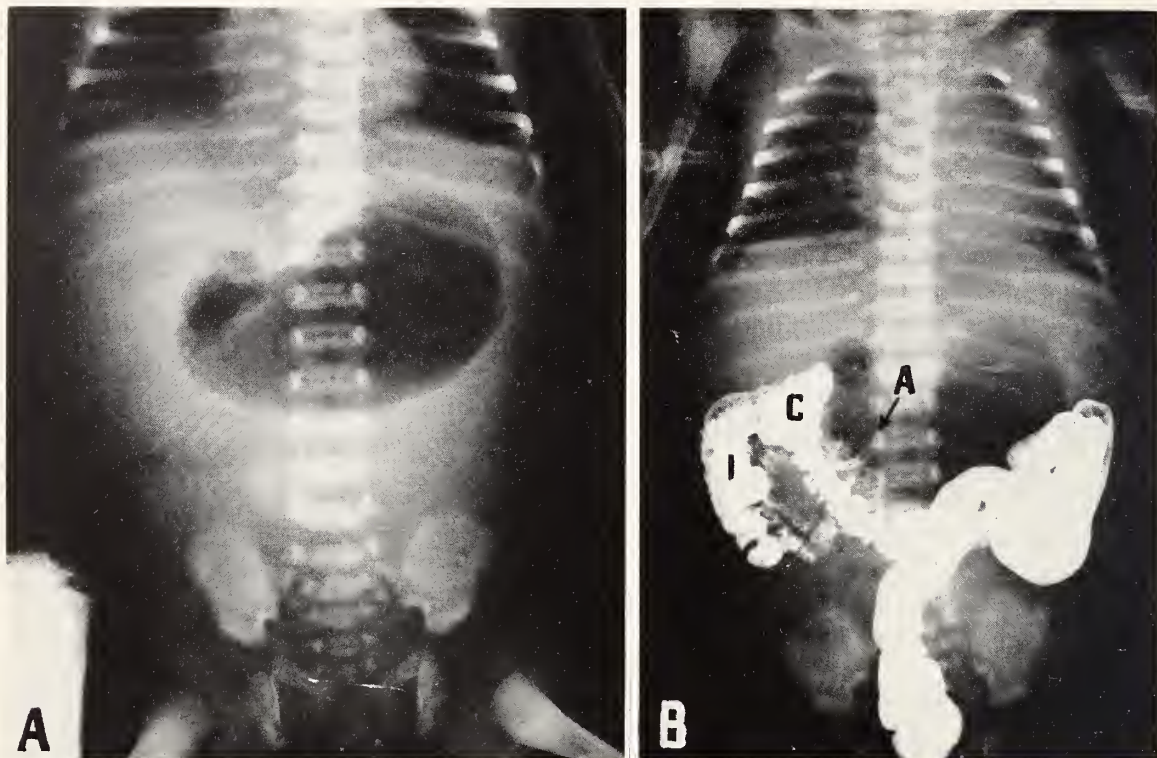


Figure 4. Roentgenograms demonstrating a high degree of duodenal obstruction with rather marked gastric dilation due to malrotation of the intestines (A) on a plain flat film of the abdomen and (B) after a barium enema. The cecum (C) is in the right upper quadrant at the level of obstruction. The appendix (A) and the ileum (I) are visualized.

occasional case, the preoperative physical and roentgenographic findings are seldom diagnostic. Excision of the duplication is rarely possible. For this reason resection of the duplication and adjacent intestine followed by primary anastomosis is the treatment of choice in the vast majority of these cases.

#### MESENTERIC CYSTS

Some mesenteric cysts which are free of intestinal attachments may be of enteric as well as of lymphatic origin. These cysts usually are filled with serous or chylous fluid and produce symptoms of slowly progressive abdominal enlargement associated, at times, with pain. In an occasional case, obstruction may result from angulation of adjacent intestine or from direct pressure on it.<sup>21</sup>

Radiologic demonstration of a large space-occupying mass should suggest the possible presence of a free mesenteric cyst.<sup>14</sup> Most of these cysts can be enucleated and excised. A few cysts, however, are intimately adherent to mesenteric blood vessels, necessitating a local resection of intestine with its blood supply to

remove the cyst, followed by a primary anastomosis. Drainage, partial excision or marsupialization of the cyst should be avoided.

#### OMPHALOMESENTERIC DUCT ANOMALIES

A wide variety of anomalies and complications may result from complete or partial persistence of omphalomesenteric duct remnants. When the duct remains patent throughout, there is a fecal fistula at the umbilicus. Ileal obstruction may occur from intussusception or prolapse of ileum through the persistent duct.<sup>18</sup> This most often takes place during the first month of life. Treatment should be carried out promptly, as soon as the inverted, mucosa-covered intestine prolapses through the umbilical area on to the abdominal wall. The intussusception rarely can be reduced without operation and laparotomy with reduction of the prolapse and excision of the omphalomesenteric duct appears to be the treatment of choice.

The distal portion of the omphalomesenteric duct may obliterate, remaining as a fibrous cord attached distally to the umbilicus and proximally



to a Meckel's diverticulum. In these cases, obstruction may result from a loop of intestine being caught over this band. The obstruction may be relieved by operative lysis of the cord. Resection of the Meckel's diverticulum should depend on the degree of obstruction and the patient's condition. If the patient's condition is critical or the obstruction severe and of long-standing, resection should be deferred and only relief of the obstruction attempted. The diverticulum must, of course, be resected if its viability is impaired.

The commonest omphalomesenteric duct anomaly is the Meckel's diverticulum which is not attached to the umbilicus. This anomaly may cause intestinal obstruction by acting as the leading point for an intussusception. Prompt reduction of the intussusception is essential. The diverticulum should be excised when it is inflamed, perforated or non-viable. Otherwise, it is, perhaps, best to defer Meckel's diverticulectomy until later due to the risk of contaminating an already traumatized peritoneal cavity.

### MECONIUM ILEUS

The most serious type of congenital neonatal intestinal obstruction is due to plugging of the intestinal lumen with sticky, mucilaginous meconium which has the consistency of tar. The association of this condition with cystic fibrosis of the pancreas was first reported in 1905 by Landsteiner<sup>10</sup> who regarded the pancreatic changes as secondary to the meconium ileus. However, the more recent studies of Farber<sup>4</sup> suggest that the pancreatic fibrosis is primary and that the abnormal, tenacious meconium is due to the absence of digesting pancreatic enzymes. He has termed this condition muco-viscidosis and has shown that a 1 to 10 per cent saline solution of pancreatin will convert the tarry meconium into a semiliquid or liquid state. It also appears that there is a high associated incidence of progressive pulmonary atelectasis, presumably due to bronchial obstruction by the secretion of too viscid mucus in the tracheo-bronchial system. The atelectasis will often lead to death even when the intestinal obstruction has been relieved by ileotomy and instillation of pancreatic enzymes. It should be noted that considerable variation may be expected in the clinical picture and the degree of obstruction. In-

deed, cystic pancreatic fibrosis may exist without evidence of meconium ileus.

A preoperative diagnosis of meconium ileus may often be made from roentgenographic studies. Neuhauser<sup>20</sup> has described the appearance of many small gas bubbles beyond the point of apparent obstruction as typical of meconium ileus. It was not until 1948 that the first long-term operative successes were reported by Hiatt and Wilson.<sup>7</sup> In some cases it appears that ileotomy will permit the removal of the obstructing meconium, whereas, in others, resection of the occluded segment of ileum may be necessary. The use of the Mikulicz double enterostomy is also of value in these cases. Pancreatic enzymes should be given postoperatively.

### INCARCERATED CONGENITAL HERNIAS

The herniation of intestine into congenital defects and its incarceration there frequently produces intestinal obstruction in infancy and childhood. The majority of incarcerations occur in association with congenital inguinal hernias, hernias which result from the inadequate obliteration of the processus vaginalis which accompanies the descent of the testes into the scrotum. The incarceration may progress with edema, intestinal obstruction and impairment of intestinal blood supply to strangulation and ultimate gangrene and perforation. For these reasons, early reduction of incarcerated hernias is of considerable importance. Often the incarcerated hernia will have reduced spontaneously before the patient is seen by a physician or prior to hospital admission. In other cases, reduction may be effected during a few hours of observation supplemented by the Trendelenburg position, sedation and cold applications. If reduction does not occur within a few hours, operative reduction is imperative.

Herniorrhaphy in the presence of incarceration is somewhat more difficult than in its absence due to distortion of local structures by the accompanying edema. The incarcerated intestine should always be inspected carefully before permitting it to slip back into the peritoneal cavity in order to avoid overlooking a non-viable segment. Non-viable intestine should, of course, be resected if present. Since congenital inguinal hernias are due to the congenital presence of a

hernia sac rather than to muscle or fascial weakness in this area, simple excision of the sac and ligation of its neck is all that is necessary to prevent recurrence. Care should be taken in approximating the inguinal structures to avoid spermatic cord constriction which might lead to ischemic testicular atrophy.

Incarceration is less frequently encountered in cases of umbilical or diaphragmatic hernia. Diaphragmatic hernias more often produce symptoms of respiratory distress from pulmonary compression. The diagnosis is more difficult, to be sure, in the relatively uncommon instances of intra-abdominal hernia incarceration, accounting for the greater delay in operative relief of obstruction and the higher associated mortality in these cases. The commonest site of intra-abdominal herniation is through a defect in the mesentery, particularly in the region of the distal ileum.<sup>1</sup> Other sites of herniation are paraduodenal defects in the region of the ligament of Treitz, the foramen of Winslow, defects in the ascending mesocolon and defects in the broad ligament. The operative management of these hernias is basically the same, namely, reduction of the hernia, repair of the defect and resection, if necessary, of non-viable intestine.

**Figure 5.** Radiologic demonstration of marked congenital megacolon in a 7-year old girl due to functional obstruction from an area of recto-sigmoid spasm (arrow.)



## FUNCTIONAL OBSTRUCTIONS

It is becoming increasingly apparent that both acute and chronic intestinal obstruction may occur in infants and children in the absence of any demonstrable gross lesion. This type of obstruction is best classified as functional, due to the absence of myenteric plexus ganglion cells with resultant spasm and lack of peristaltic activity in the involved segment. The level of the obstruction may vary from the rectosigmoid area to the terminal ileum. The rectosigmoid, the splenic flexure and the terminal ileum appear to be most frequently involved in the acute obstructions, whereas the obstruction in chronic cases occurs predominantly at the rectosigmoid, producing, with the passage of time, congenital megacolon (Hirschsprung's disease) (Fig. 5). Dalla Valle,<sup>2</sup> in 1920, was the first to describe the absence of distal colonic myenteric plexus ganglion cells in megacolon. In an excellent study of this problem, Zuelzer and Wilson<sup>25</sup> have shown that functional aganglionic obstruction of an acute type may occur during the first few days or weeks of life (Fig. 6). It is also of interest that 5 of their 11 cases were from one family.

The soundest approach to the definitive surgical management of cases of functional obstruction is that advocated by Swenson.<sup>23</sup> He advised resection of the aganglionic segment by means of a combined abdominoperineal pull-through oper-

**Figure 6.** Barium enema portrayal of an area of marked recto-sigmoid spasm (arrow) in a 2-week old male infant. The patient had had symptoms of intermittent acute large bowel obstruction since shortly after birth. No myenteric plexus ganglion cells were found in this area on subsequent microscopic examination following the Swenson operation.





ation with preservation of the anal sphincter. His experience with this procedure has been quite encouraging. Frozen section studies for myenteric plexus ganglion cells should be carried out at operation to be certain that all of the abnormally innervated bowel has been resected. It is also of importance that urinary bladder function be carefully regulated postoperatively. Colostomy is the preferred treatment in cases of acute obstruction, removal of the aganglionic segment being deferred until a later date.

### IMPERFORATE ANUS

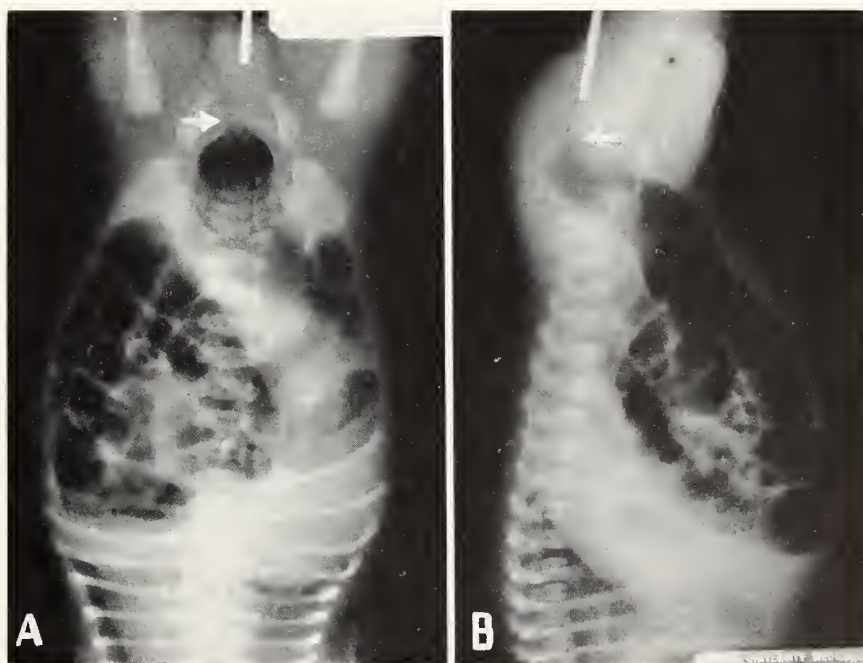
Congenital anorectal imperforation is one of the commoner causes of neonatal intestinal obstruction. Ladd and Gross<sup>9</sup> divided these anomalies into four clinical types. In Type 1 there is a stenosis of the rectum or anus, the hindgut being otherwise patent. The blind ending rectal pouch is low in Type 2, whereas it is somewhat higher in Type 3, with several centimeters often separating it from the skin of the perineum. An atresia of the rectum exists in Type 4, the anus and lower rectum appearing normal. The majority of the cases are of Type 3 (75 per cent). Approximately 17 per cent are of Type 2, and the remaining cases are divided between the relatively rare Types 1 and 4. Type classification may be made both by local examination and by roentgenograms in the inverted position, as described by Wangenstein and Rice<sup>24</sup> (Fig. 7).

In addition, congenital fistulas may be expected to exist between the blind end of the hindgut and the bladder, uretha, perineum or vagina in approximately 60 per cent of the cases.

Both the method of treatment and the prognosis vary with the type of malformation. Repeated anorectal dilatation is regarded as the most satisfactory treatment in Type 1. Type 2 patients are best managed by excision of the obstructing membrane with perineal anoplasty. The results in both Type 1 and 2 are good. The mortality is low and normal bowel movement with a functioning anal sphincter is the rule. Until recently the vast majority of Type 3 patients were treated by perineal anoplasty. The limitations of this method have resulted in the more frequent utilization of the combined abdominal and perineal anoplasty.<sup>16</sup> It should be emphasized that careful muco-cutaneous approximation should be carried out without tension and that repeated anal dilations are essential postoperatively to prevent suture line stricture formation. The long-term mortality in Type 3 patients is high and a functioning anal sphincter is seldom obtained. Recent experience suggests that the rare and frequently fatal Type 4 malformation is best attacked by the combined abdominal and perineal approach.

The mortality aspects of anorectal malformations is complicated by the unusually high incidence of associated anomalies, many of which

Figure 7. Upside-down roentgen studies on a new-born infant with imperforate anus in the (A) anterior-posterior and (B) lateral positions showing the distance between the skin in the region of the anal dimple (metallic marker) and the blind ending rectal pouch (arrow).





may lead to the death of the patient even when the anorectal obstruction has been satisfactorily relieved.<sup>17</sup> These associated abnormalities may be expected to occur in over 70 per cent of the patients and their prompt recognition is of great importance. The urinary tract is most often involved. Some of these associated anomalies, such as esophageal atresia with tracheoesophageal fistula, require emergency treatment.

### SUMMARY

In recent years an increasing awareness of the potential causes of congenital gastrointestinal tract obstruction has resulted in their earlier recognition and in progressive improvements of the operative techniques for their management. The availability of antibiotics and methods for gastrointestinal tract decompression have also proved to be of considerable value. Our clearer understanding of fluid and electrolyte balance and its importance in both pre- and postoperative care of these patients has led to the more judicious regulation of parenteral replacement therapy. It is to be hoped that a continuation of current advances will lead to further reduction in the hazards of gastrointestinal obstruction due to congenital malformations in infants and children.

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# The *Journal*

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## ADMISSION TO MEDICAL SCHOOL

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES has recently published a statistical study of the geographic distribution of medical education facilities and medical school applicants. This is of interest since medical schools are not by any means uniformly distributed throughout the United States.

There are 10 states which do not have a medical school. Most tax supported schools have residency requirements for most of their admissions. Both of these facts tend to produce a considerable variation in availability of medical education on a basis of state boundaries.

However, when considered on a basis of 9 major geographical divisions, the availability of medical schools is surprisingly uniform. For the entire country there are 5 freshman places available for every 100,000 population. Four of the 9 geographical divisions have 5 places per 100,

000, 1 has 4 places and 2 have 6 places. Only 2 geographical divisions, the Pacific coast and the Rocky Mountain divisions have but 3 places.

The availability of medical education becomes even more uniform when actual admissions are studied. All geographical divisions have 5 or 6 admissions to medical schools in their own area or another, with the exception of the Pacific coast and New England each of which have 4.

Indiana is very close to the average. There are 4 available freshman places per 100,000 population, and when admissions of Indiana residents to schools outside the state are added in, there are 5 admissions per 100,000. Hoosiers are a little above the average in the percentage of applicants who are accepted. The national average is 55% acceptance. Residents of Indiana enjoy a 59% acceptance rate.

A correlation which was established by the survey and which probably results from the high

cost of a medical education is that the number of applicants per state population varies directly with the per capita income of the residents. The number of applicants was found to bear no relation to the number of liberal arts colleges in each state, nor to the average income of the physicians of the area.

There is a positive relationship between number of applicants and the number of medical

schools in the state; and also with the number of physicians practicing in each state. Both the number of schools and the number of practitioners seems to influence the number of applicants.

In general, the results of this survey are proportionately the same as in former years when the total number of medical school applicants was much higher.

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## CIVIL SERVICE CHECKING INSURANCE DATA

**T**HE CIVIL SERVICE COMMISSION recently has been gathering data and considering plans in regard to the provision of health insurance policies to all federal employees.

A plan whereby the government would contribute \$26.00 per year for each employee, with an equal amount to be deducted from salary, was considered by the last Congress but not enacted. The program as introduced also included permission for an employee to voluntarily authorize additional pay deductions (not to be matched), if he wished to purchase insurance of greater cost.

Under the proposed law, heads of departments and agencies were to decide which policies would be approved, and after consultations with workers would also determine whether coverage would be arranged on a national or local basis.

The present investigation of various contracts

as offered by Blue Cross-Blue Shield and commercial carriers is for the purpose of simplifying the review of the many policies available.

At present many federal employees are protected by Blue Cross-Blue Shield local plans—better than half a million in Blue Shield and over three-quarters of a million in Blue Cross. These are handled on a group basis with one member making the collections, and no payroll deductions or government participation is involved.

The proposed legislation was introduced near the end of the 83rd Congress. It was too late for enactment, but no serious objections to the bill were expressed at that time. The interest of the administration in the new proposal is evidenced by the fact that a group of representatives of the important branches of the government have been selected to consider the data collected by the Civil Service Commission.

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## INFORMATION AVAILABLE ON MEDICAL SCHOLARSHIPS

Requests for information on available medical scholarships and loans for a medical education have prompted the publication of a comprehensive new pamphlet on the subject by the AMA's Council on Rural Health in cooperation with the Department of Public Relations. Scheduled for release in April, this booklet will contain a compilation, by state, of pertinent information regarding all types of medical scholarships and loan funds now available through medical society, governmental and other special funds. Copies may be obtained from the Council on Rural Health.



## The President's Page

THE 1954 CONVENTION of the Indiana State Medical Association is now history. In retrospect I would like to comment about it. It certainly presented the finest scientific and commercial exhibits I have had the pleasure to witness. The mechanical development of a convention presents unending details likely not appreciated by the average member. The success of this meeting is a tribute to the headquarters' staff, the members of committees, essayists, and others who worked untiringly to bring it about. The general comment seemed to be all favorable as to the quality of scientific papers and instructional courses.

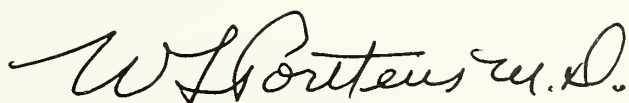
The business of organized medicine as exemplified in the meetings of the House of Delegates, council, executive committee, and reference committees is a picture of democracy at work.

The reference committees spent unhurried hours in weighing evidence pro and con on resolutions referred to them. Their reports were succinct and illuminating. When these reports are presented to the House, and duly passed, they should reflect a spirit of give and take and be supported by all our members. Freedom of discussion, both on the floor of the House and in the committee meetings, should permit anyone to voice an opinion. Once an issue is decided we must, for the sake of unity, abide by the will of the majority until such time, when, by due process, the policy can be changed.

I should like to stress the early filing of resolutions in order that county societies and delegates may have ample time for real consideration of any policy changes. Resolutions referred to committees should be posted under the committee name, with the place, date, and hour of meeting. This will enable members to have sufficient information concerning matters on which they desire to appear. Our House of Delegates meeting sometimes becomes a jumble of parliamentary procedure and often issues are lost in a maze of rulings, about which many know little and care less. Often issues are clouded by personalities, and human nature being what it is, we find delegates voting for or against some motion on this basis. Simplification and clarification of individual issues should be tantamount.

This last month of 1954 should bring us to the point of yearly inventory. How have we conducted our private practice? Would it hold up under the tenets of the Golden Rule? Are we improving our Public Relations, both as individuals and as an organization, and have we lived as true men of medicine under the Hippocratic Oath? These are questions I shall have to leave to you to answer.

May the Yuletide Season bring you and yours that priceless gift of Peace on Earth and Good Will toward Men.



"It is a very hard undertaking to seek to please everybody."

(Publius Syrus)

## The President's Address—1954\*

WM. HARRY HOWARD, M.D.

*Hammond*

**I**N THE LAST FEW MONTHS I have had the privilege of attending the annual state meetings of all of our surrounding states. I saw on each program the words "Address by President—15 Minutes;" or "Address by President—20 Minutes." I don't know whether this was placed there to attract a crowd or to hold the speaker down. I believe I can hold the 20-minute time.

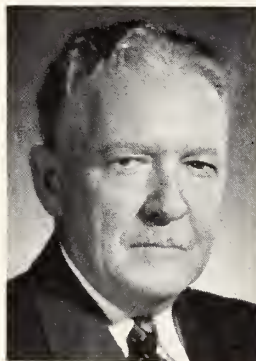
Seriously, I think the purpose of the President's address is to cover the high points in the past year and possibly make a few suggestions but not to preach. We have had enough criticism in the past and our deficiencies always make front page news.

First, I want to thank the members of my committees who have spent so many hours doing the necessary work of the Association. These committees have really worked, as you can see by reading their reports in the handbooks and *THE JOURNAL*. The Executive Committee has met every month to handle the affairs assigned to it between the meetings of the Council. From the length of the agenda each Sunday the Association has been and is forever reaching out and taking a more active part in the affairs of medicine.

Our Committee on Medical Education and Hospitals spent two whole Sundays with the National Hospital Accreditation Board trying to work out standards for the care of the patient according to the training, ability and integrity of the members of the staff in our hospitals; also to arrive at a method of appeal from unfavorable rulings of the commission. This culminated in a resolution to the A.M.A. which was passed at the session in Chicago.

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\* The address of Doctor Howard, who served as 1953-1954 president of Indiana State Medical Association, was delivered at the annual President's Night program in the Murat Theatre, Indianapolis, October 26, 1954.



**Dr. Harry Howard of Hammond came up through the ranks to the presidency of I.S.M.A. He had been president of Lake County Medical Society, Tenth District Councilor, chairman of the Section on Surgery and had held many committee appointments.**

Our two field men, Mr. Bush and Mr. Amick, have covered the northern and southern parts of the state respectively. They have brought the State Association a little nearer to the men in practice and have also helped many of the societies with recorded programs. Incidentally, they each have new cameras and many of you have seen your pictures in *THE JOURNAL*. We feel this adds to reader interest in the magazine. They have also cooperated with the Blue Shield in putting on programs for the doctors' office assistants, encouraging them to take more care of their public relations responsibilities.

The Council appropriated several thousands of dollars for a public relations program. The program, starting this fall, will be heard on the local radio stations in each community. They also plan to have television programs.

One of the outstanding accomplishments has been the development of our recording library. We have one of the largest libraries of recordings in the country. Most of the interesting papers have been recorded from meetings in Indiana and surrounding states. It was the Indiana resolution to the A.M.A. that started the recording of the talks given at the clinical and annual sessions of the national organization. Incidentally, if any of you are unfortunate enough to break a leg, you can take a postgraduate course via the tape recorder.

The Board of Appeals on Patient-Physician Relations has asked that wider distribution of the fact that we have such a committee be made through publicity. It is essential that the public know that we are trying to keep our own house regulated. One main factor in avoiding misunderstandings is the prior discussion of fees. The patient who understands what the fee will be prior to surgery or a delivery is better able to evaluate the service and much more likely to pay it promptly.

The voluntary health agencies are doing an excellent job but in their enthusiasm they are apt to over-emphasize the importance of their particular field. I believe more physicians should take an active part in these organizations and help to lead them rather than be led by the health agencies.

The Committee on Cancer brought in a report showing the futility of mutilating operations for cancer when the purpose of the operation was to make the patient more comfortable.

The Indiana State Heart Committee has worked in close liaison with the Indiana State Heart Foundation in its efforts to bring to people the best education and treatment in its field.

The new head of the Board of Health, Dr. Andrew Offutt, was before the Executive Committee to get its approval of some of his new projects. They include:

1. Start testing air-pollution in several of our cities.
2. To appoint speech and hearing specialists to coordinate the local programs under the new law but not to set up any clinics.
3. He is demanding that the Board of Health have written permission from the local county society before going into a community to do mass chest surveys.

The Medical Forum which was pioneered in Evansville is gradually spreading over the state. The forum, with its use of the local doctors, is doing an excellent job of bringing a better understanding of medical subjects to the lay public.

It is no mere coincidence that Illinois, Indiana and Ohio have indemnity plans in the Blue Shield movement. They reflect the thinking of the doctors in these three midwest states. They are indi-

viduals of the first order. It makes no difference to them that seventy per cent of the country is insured under service plans and only thirty in the indemnity type. They may accept the indemnity as full payment but reserve the right to charge more if they think it is justified.

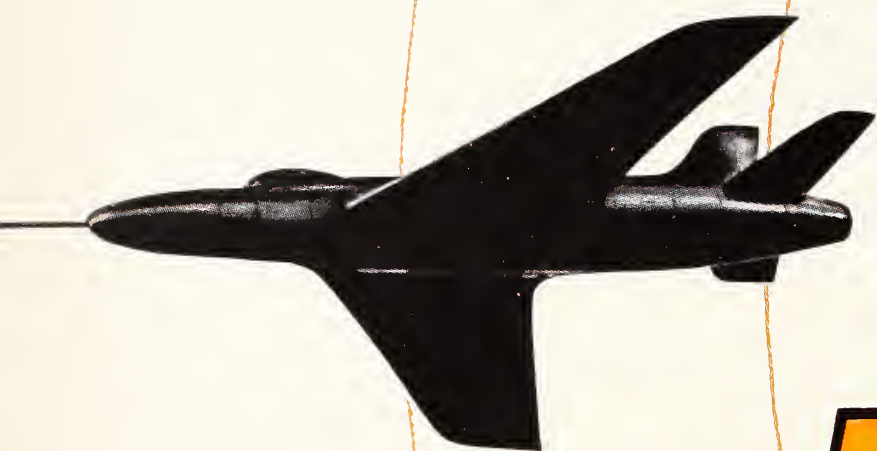
At the National Blue Shield commission meeting this fall, ways and means were discussed of how to make the indemnity of the Blue Shield schedule more nearly cover the entire medical bill of the hourly wage group. Given an adequate schedule this is usually accomplished. There is always the possibility that in so doing we may price ourselves out of the market. One of my friends on the Blue Shield commission suggested the slogan be used—The Kaisers are Coming. This has been very effective.

In California some of these plans are a real threat to the private practice of medicine. If they should move in to our cities—they would build their own hospitals and furnish complete medical and surgical care to the group they covered. Many of the medical bills in Congress in the past year contained provisions for the expansion of this type of clinic. One of them, the reinsurance bill, failed to pass the Congress. It is true that their group is staffed for the most part by younger men not too adequately compensated who move on to their own private practice when they are able. The patient may get several different physicians during a short illness if he stays home or he may be sent many miles away to one of their hospitals. One thing we do know is that such service is entirely impersonal.

It is up to organized medicine to see that adequate medical insurance coverage is available and that the full choice of physician and hospital are maintained; that our emergency call service is working properly, and our grievance committee functioning efficiently. We know that the private practice of medicine is more satisfactory to the patient, but it takes time and effort to keep it that way. In England during the last year, in spite of the fact they already pay for a panel doctor under the National Plan and where their economic level has always been far below ours, they have been trying desperately to get some form of private insurance which will allow them to employ a private physician. Let's

(Continued on Page 1406)





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*in record time*

# ROMYCIN\*

Hydrochloride  
Tetracycline HCl Lederle

ACHROMYCIN, new broad-spectrum antibiotic, has set an unusual record for rapid acceptance by physicians throughout the country. Within a few months of its introduction, ACHROMYCIN is being widely used in private practice, hospitals and clinics. A number of successful clinical tests have now been completed and are being reported.

ACHROMYCIN has true broad-spectrum activity, effective against Gram-positive and Gram-negative organisms, as well as virus-like and mixed infections.

ACHROMYCIN has notable stability, provides prompt diffusion in body tissues and fluids.

ACHROMYCIN has the advantage of minimal side reactions.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York



\*REG. U.S. PAT. OFF.

not go to sleep as our English cousins did during the war.

Speaking again of the midwest states, a meeting was held in Indianapolis this spring at which time the President, Executive Secretary and the Chairman of the Council of the states of Illinois, Ohio, Michigan, Kentucky and Wisconsin were present for the purpose of discussing matters of mutual interest to the combined group. It must have been a success as we are all invited to a similar meeting in Lansing, Michigan this fall and a permanent organization has been set up. This group has, of course, a great deal in common.

During the past year the Federal Re-insurance bill was defeated in Congress. The whole insurance industry, including the Blue Shield, was unanimously against the bill. Many of the newspapers now are reversing their stand. To quote in part from your Indianapolis Star, "It is a sound principle of government that government should never invade a social welfare field in which private or semi-private agencies are able and willing to provide what is needed. It seems clear that the insurance industry has the capacity and is now showing the willingness to handle this special and long neglected field of catastrophic health insurance."

The best way to prevent socialized medicine

or socialized insurance is to eliminate through private effort any need or demand for them and to do so before government gets started in the field.

The organization of our hospitals which is sweeping the country is to be commended as long as it insures better and more adequate care of the patient. At the same time we must be sure that the general practitioner has a place to work and is allowed to do all the things that are commensurate with his ability.

The individuality of the Indiana doctors (together with the rest of the physicians in the country) demonstrated, by the flood of telegrams to the Ways and Means Committee in Congress, that we wanted no part of social security. Many who would have benefitted financially felt they could not forsake the principle of independence and freedom from subsidy by the federal government that has so long characterized medical thinking.

I want to say in closing that I have enjoyed my year as your President. It turned out to be more work than I had counted on but I have been amply repaid by the splendid cooperation I have had with my associates and the many new friends I have made. If I have made any small contribution to my chosen profession I will feel that I have done my duty.

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## *The Woman's Auxiliary*

### REPORTS TO I. S. M. A.

The Thanksgiving season is just past, and Christmas is now upon us. You, in this beloved country, have so much to be thankful for, and you, as members of the medical profession, have had much to do with keeping our institutions free. Now, when you are preparing gifts for relatives and friends, I hope you will remember to make a gift to A.M.E.F. This amount will be tax-exempt, and will help the medical schools to provide even better facilities, for those who come after you, than you have enjoyed; and will help repay those who have gone before you, and who provided the schools which you attended. Also, please give your wife a small share of this contribution for her Auxiliary fund!

I'm sure all the members of the Auxiliary join me in wishing you, our husbands, and members of the medical profession, a "Merry Christmas, and a Happy New Year."

MRS. HARRY C. HARVEY, *President*



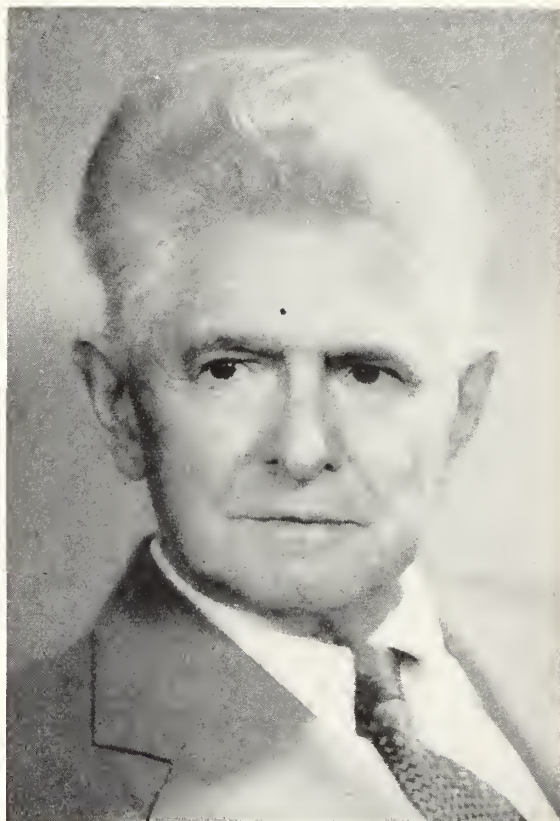
## Dr. A. E. Stinson, Fulton County, Named Indiana's "Physician of the Year"

**T**HE PATIENT, UNDERSTANDING CARE, with or without fees, which Dr. Arthur E. Stinson has given residents of Fulton county for 51 years has been recognized by the House of Delegates of the Indiana State Medical Association. Dr. Stinson was selected from a field of several candidates for the high honor of "Physician of the Year". Nominated by the Fulton County Medical Society, Dr. "Dick" Stinson accepted the title and plaque, which is a permanent symbol of the honor, with the same eagerness which has marked his entire career.

Born in Cleveland, Ohio in 1879, he moved with his parents to Fulton county when he was two years old. His steady, unobtrusive climb to a long and useful career began when he started taking piano lessons as a child to overcome partial paralysis of his hands. Eventually he regained use of his fingers. He went from the old frame Possum Hollow grade school to Rochester High school and rode horseback six miles each way daily until his graduation. Graduating in 1897 he entered Rochester Normal School for two years' study and studied simultaneously in the office of Dr. Sam Terry. Formal education was completed in 1903 when he completed a four year course at the College of Physicians and Surgeons in Indianapolis and received his medical degree.

His career began and has continued in the little Fulton county town of Athens where the 150 to 200 residents soon learned to know Dr. "Dick" as he made house calls on his bicycle and later in a horse-drawn buggy. Through the years he has been on call at all hours, has delivered nearly 4,000 babies (many not paid for), and has found time to listen to his patients' problems, both physical and personal.

Several months ago he was hospitalized with a fractured hip, his first incapacitating illness. As soon as released and home, his patients began making house calls in reverse—they came to him. He now follows his usual routine, seeing patients in his combined home and office and making



A. E. STINSON, M.D.

house calls whenever needed with the aid of a walker and with Mrs. Stinson acting as chauffeur. She is also practical nurse and bookkeeper.

In accepting his title and plaque from Dr. Wm. Harry Howard, president at the annual banquet in Indianapolis, Dr. Stinson publicly acknowledged the help Mrs. Stinson has given him from the early days when she gave piano lessons to help with family finances to the present when her triple role of chauffeur-nurse-bookkeeper makes it possible for Dr. "Dick" to continue to serve his many patients.

The 1954 Physician of the Year has served many years as Fulton County Medical Society secretary and as a member of several committees of the Indiana State Medical Association.

# Capsule Report of Convention

**Fact**—Total registration, 2,443 . . . 1,366 members, 73 guest physicians, 53 interns and residents for a total physician registration of 1,492 . . . many stayed all through the convention. Add 135 medical students, 33 technicians, 11 registered nurses, 262 Auxiliary members, 368 exhibitors, and 137 guests to get the total.

**Fancy**—A sparkling white Colonial cottage front formed the entrance to Murat Temple Lounge room where exhibits were housed . . . it was the "house" of the Indiana State Medical Association . . . white curtained windows, green shutters, flower boxes filled with fresh flowers . . . as you entered you were greeted by a charming hostess . . . the beautiful new 1955 model Studebaker which was top prize of the convention stood on a grass plot outside the door.

**Exhibits**—Both technical and scientific exhibits broke all records for I.S.M.A. conventions . . . in number and quality . . . attendants at all booths reported interest keen in products, equipment and educational material.

**Golf**—63 players started—46 finished at Meridian Hills course . . . Boyd Burkhardt, Tipton, carded a low gross of 73; James Browning, Indianapolis, low gross of 76; Loren Martin, Indianapolis, low net.

**Trap Shoot**—High overall score made by R. M. Engle . . . others who participated and placed in the event at Indianapolis Gun Club were M. C. Salb, C. M. Donahue, H. G. Petitjean, Hugh Williams, Byron Nixon, W. Shullenberger.

**Instructional Courses**—Capacity registration was reported for most of the 30 instructional courses offered . . . those taking courses voiced appreciation for the quality of instruction . . . physicians who served as instructors were Roland E. Miller, Wm. B. Ferguson, Lafayette; Francis E. Stout, Thomas C. Moore and M. F. Greiber, Muncie; Richard C. Stauffer, Fort Wayne; James V. Cassady, George E. Gates, Carl S. Culbertson and Herman H. Rodin, South Bend; David McKinley, Lowell I. Thomas, Robert Girk, C. A. Stayton, Jr., Edwin A. Lawrence, Glenn W. Irwin, W. Donald Close, M. H. Nourse, F. T. Romberger, and M. E. Thomas, all of Indianapolis; Wm. C. Vance and F. B. Warrick, Richmond; E. S. Jones, Hammond; Henry Alderfer, Marion; R. R. Bucholz, L. Edward Gaul and G. T. Hermann, Evansville; Joseph E. Kopcha, Gary; and Glenn B. Patrick, Elkhart.

**Monday Night**—Traditional stag party for doctors, exhibitors, newspapermen and guests . . . dinner for women physicians . . . dinner for women exhibitors . . . dinner for past presidents of Woman's Auxiliary . . . Crusty Crumbs, Tippecanoe county band, entertain Dixieland style at stag party and later open show on Murat stage . . . evening climaxed by mind-reading feats of Mac Murray.

**General Meetings**—Tuesday and Wednesday brought high calibre speakers to the Murat theatre . . . audiences Tuesday were large and responsive . . . attendance Wednesday was reduced by absence of many delegates who were in a longer than scheduled session of the House . . . members report papers presented were unusually fine.

**Luncheons**—Special organizations and committees met both Tuesday and Wednesday noon for luncheons and reunions. Attendance was good and programs, if any, reported outstanding.

**President's Night**—Traditionally President's Night is one of the real highlights of the convention . . . 1954 was no exception . . . Dr. Wm. Harry Howard delivered a short, pertinent address . . . some of the very finest entertainment ever presented at an I.S.M.A. convention was then introduced . . . Dr. Fabien Sevitzy and a major part of the Indianapolis Symphony Orchestra shared the spotlight graciously with the pert and talented Ethel Smith, organist, humorist and actress.

**Section Meetings**—All Section meetings were held Wednesday afternoon and many physicians from over the state attended . . . here again the quality of the papers presented was reported as exceptional . . . consensus was that fine planning had gone into all scientific sessions . . . Section officers were elected.

**Fifty Year Club**—C. Walter McCarty, editor of the Indianapolis News, spoke informally to members of the club and their families at the annual reception held to honor the men who have given long years of service to lessen suffering . . . it was really "their day" . . . several hours later they were introduced individually at the annual banquet and saw one of their members named Physician of the Year and a second given special recognition as the oldest former president in attendance and for his long years of service to the profession.

**Annual Dinner**—Dr. Howard presides at a formal I.S.M.A. meeting for the last time as president . . . the Fifty Year Club members are introduced . . . Dr. A. E. Stinson is presented as the Physician of the Year . . . Dr. Charles S. Bond, Richmond, oldest living former president of I.S.M.A. . . . he's 98 . . . was given a rousing ovation as special tribute was paid to him for his more than 70 years as a doctor . . . Lieutenant Governor Harold W. Handley represented the State of Indiana making a brief talk in which he stressed the vital role the medical profession plays in the lives of all citizens . . . visiting dignitaries from other state medical associations and from the A.M.A. headquarters were introduced by Dr. Howard . . . highlight of the evening was the talk by Dr. Elmer Hess, Erie, Pennsylvania . . . the President-elect of A.M.A. spoke of the addition of new class A medical schools which will provide more doctors . . . told of the fine part physicians all over the U. S. are playing in furnishing funds for medical schools . . . paid tribute to the record contributions Indiana doctors have made . . . spoke off-the-cuff about what he felt requisites are for successful physicians . . . climax of the evening came with the transfer of the gavel and its authority from Dr. Howard to Dr. Walter L. Portteus, Franklin . . . Dr. Portteus' response was a sincere plea for unity, progress and greater activity on the part of individual members both within the organization and on a civic level.

**Who Won the Prizes?**—Luckiest doctor who attended the convention was Dr. Franklin K. Beeler, 1010 Jackson Street, Anderson, who was awarded the 1955 Studebaker Commander Regal sedan which was on display throughout the convention . . . Dr. Beeler, a 1952 I.U. graduate who interned at St. Elizabeth's, Lafayette, had returned to Anderson and was informed of his good fortune by phone . . . also awarded at the banquet were three previously unannounced plaques for the best scientific exhibits . . . these went to Dr. Carl B. Sputh, Indianapolis, first place; Dr. L. Edward Gaul, Evansville, second; and Dr. Russell W. Lamb, Indianapolis, third . . . on Monday night the exhibitors had their chance to win three prizes . . . a trip to Nassau for two, a \$75 and a \$25 prize . . . lucky exhibitors were John H. Arns, Baxter Laboratories, Richard Pauley, Wilson's Milk, and Wallace O. MacLellan, Pitman-Moore Company.

**Official Report**—The minutes of all official meetings during convention are reported on pages 1424-1457.



## Mutual Problems of Schools and Physicians Discussed at Conference

INDIANA PHYSICIANS in cooperation with school administrators, teachers, nurses, athletic directors and dentists held the Fourth Annual Conference of Physicians and Schools on October 20 at the Student Union Building, Indiana University Medical Center.

Dr. G. O. Larson, chairman of the Indiana State Medical Association sponsoring committee, the Committee on School Health and Physical Education, and Robert Yoho, Director of the Division of Health and Physical Education, Indiana State Board of Health, greeted the 110 participants in the conference.

Areas of discussion included:

1. The Role of the Full-Time and Part-Time Physician in the School Health Program.
2. Reports from District Conferences.
3. The Importance of Physical Education to the Total Health Program.
4. Development of School Health Policies.

Dr. Louis How, South Bend, served as chairman of the group discussing "The Role of the Full-Time and Part-Time Physician in the School Health Program". He was assisted by Dr. Walter L. Portteus, Franklin; Dr. Jeanne Rybolt, Indianapolis; Clarence Biedenweg, Fort Wayne; Paul F. Boston, LaPorte, and H. E. Binford, Bloomington.

Dr. Raymond M. Borland, Bloomington, was assisted in his discussion group, "Reports from District Conferences", by Malcolm McClelland, Indianapolis; Martha Van Meter, Indianapolis;

Lorel Coleman, Petersburg; and Wilma Watt, R.N., Washington.

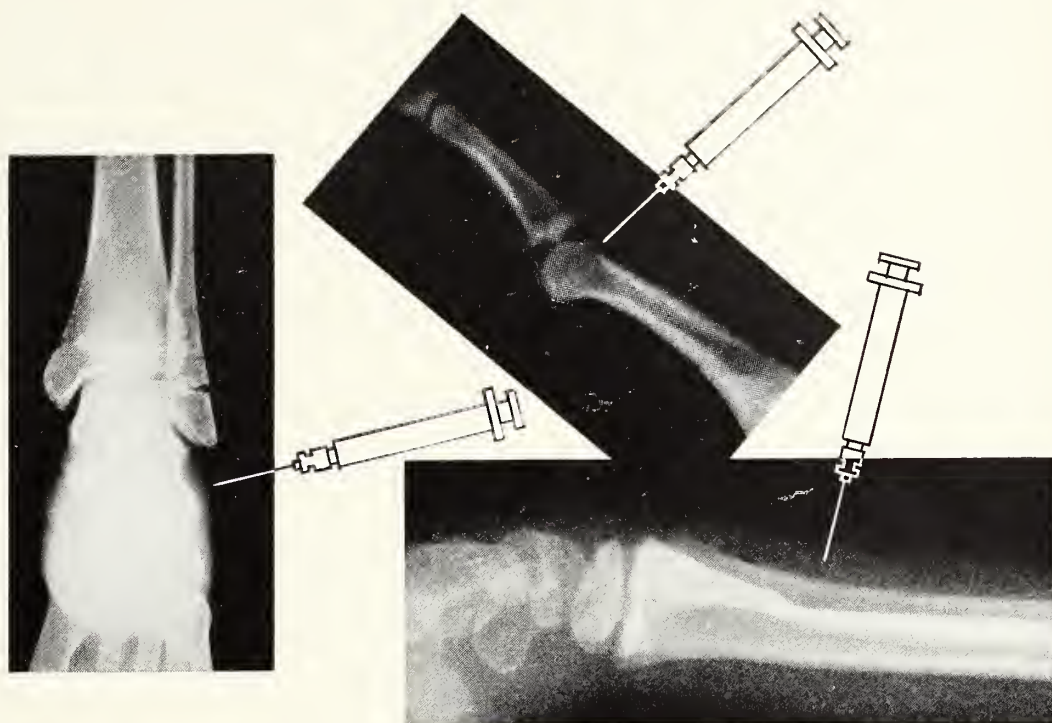
Chairman of the group which discussed "The Importance of Physical Education to the Total Health Program" was Dr. W. W. Patty of Bloomington. In this group were Cloyd J. Julian, Indianapolis; Dr. Mark Wakefield, Bloomington; Dr. Herman L. Shibler, Indianapolis; Dr. Bryan E. Quarles, Bloomington; Magdalene A. Davis, Indianapolis; and Catherine Wolf, South Bend.

Dr. G. O. Larson of LaPorte was chairman of the group on "Development of School Health Policies". Leader of this group discussion was Rubin Behlmer, Indianapolis. Other participants were Hester Beth Bland, Indianapolis; Jean Favour, R.N., Martinsville; Harold C. Benedict, Vevay; Dr. Henry C. Nester, Indianapolis; Margaret Dunham, Indianapolis, and Dr. Charles Gish, Indianapolis.

Highlighting the day's discussion was a concluding talk by Dr. D. A. Dukelow, consultant in School Health, American Medical Association.

Dr. Dukelow praised the group for its efforts to discuss and reach conclusions on problems of mutual interest and pointed out that only through such action could a better understanding of problems and viewpoints be maintained.

Participating agencies in the conference were the Indiana State Medical Association, State Board of Health, the Indiana Dental Association, the Indiana Department of Public Instruction, the Indiana State School Boards Association, the Indiana High School Athletic Association and the Indiana State Teachers Association.



## Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery<sup>1</sup> where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means<sup>1, 2</sup> of accelerating dispersion of accumulated fluids.*

Swenson<sup>2</sup> has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anes-

thesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.

## Dr. Walter U. Kennedy, New Castle, Named I.S.M.A. President-Elect

**D**R. WALTER U. KENNEDY, New Castle surgeon, was named president-elect of the Indiana State Medical Association at the second meeting of the House of Delegates, October 27.



Dr. Kennedy

His election was the culmination for him of 20 years of service to the association.

Dr. Kennedy has served the Sixth Medical District as councilor since 1945. He was chairman of the Council in 1950, 1951 and 1952. Since 1935 he has served continuously in some committee post

in the I.S.M.A. or as Henry County Medical Society secretary or district councilor.

One of his major interests has been the problem of more adequate medical insurance for everyone. He has been active in Blue Shield—the Doctors' Plan—since its inception and now serves as president of that group.

During the 1954-55 year, Doctor Kennedy will serve on the Executive Committee, and as a member of the Committee on Public Policy and Legislation.

Doctor Kennedy received his medical degree from Barnes Medical College, St. Louis. He has been licensed to practice in Indiana since 1921. His New Castle office is at 214 South 14th street and his residence at 701 South 14th street.

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### CREW HONORS SHIPMATE WITH A.M.E.F. GIFT

The crew of a Navy supply transport vessel honored a fellow crew member lost at sea by creating a memorial fund which was turned over to the American Medical Education Foundation.

The crew of the U.S.S. Achernar (AKA-53) created the fund of \$147.31 in honor of Hospital Corpsman John Phillip Blackmer, of Washington, D. C., who had hoped to become a doctor.

In a letter to the American Medical Education Foundation, the ship's commander, Capt. Charles L. Wertz, U.S.N. said:

"During his period of service aboard this ship, John Phillip Blackmer earned the genuine respect and admiration of all his associates for his professional abilities as a hospital corpsman, and their affection for him as an individual. It had been his hope, on completion of his current enlistment in the Navy, to finish his college education and to go on to medical school.

"His ability and interest in the care of patients indicated that he would have been a credit to the profession. His untimely death was a great loss to the profession, as well as to the Navy and to all who knew him.

"It is hoped that this memorial fund in the hands of the American Medical Education Foundation will help to create for some equally deserving person the opportunity for a medical education that John Phillip Blackmer had wanted so much for himself."





from all of us at  
PICKER X-RAY

## Deaths . . .

**Raymond Austin Voisinet, M.D.**, physician and surgeon for the last 30 years in Union City, died October 18 of a heart attack. He was a native of Union City where he was born April 20, 1892. He was graduated from Fordham University School of Medicine, New York in 1915. He served during World War I as a major in the Medical Corps with the United States Army in France.

Dr. Voisinet established his practice in New York City in 1919 and remained there until 1924 when he returned to Union City. He was a member of the New York State Medical Society, Medical Society of the County of New York, the Randolph County Medical Society and the Indiana State Medical Association, the American Medical Association, the American Association of Railway Surgeons. He served for many years as physician and surgeon for the New York Central and Pennsylvania Railroads. In addition to his professional affiliations he was a member of church, veteran and lodge groups.

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**Leroy Fenton Bills, M.D.**, 74, died October 26 at Hillcrest farm, near Culver where he had lived since his retirement in 1947. He had practiced in Gary for 22 years, where he was associated with his brother, R. N. Bills, M.D. During that time he had been a member of the staffs of Mercy and Methodist hospitals and in 1938 had served as Gary health commissioner.

He was a graduate of the Medical College of Indiana at Indianapolis in 1904. His death occurred a few hours before he was to go to Indianapolis to attend the annual dinner of Indiana State Medical Association where he was to have been honored with other members of the 50 Year Club. He had received his certificate and 50

year pin a week previously. He was a member of Marshall County Medical Society, the Indiana State and American Medical Associations. He was also active in Masonic organizations and was a World War I veteran.

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**Francis Clarke Guthrie, M.D.**, 60, who practiced for many years in Anderson, died October 26 in Vero Beach, Florida where he had made his home for the last year. He was on inactive status, due to a heart condition.

Dr. Guthrie was a 1920 graduate of Indiana University School of Medicine. He was formerly active in Madison County Medical Society affairs. He served as delegate to the I.S.M.A. House of Delegates in 1936. Dr. Guthrie was a member of his county society, the Indiana State and American Medical Associations.

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**Homer B. Annis, M.D.**, president of Wells County Medical Society, died November 1 of coronary thrombosis at Bluffton. He was 72 years old.

Dr. Annis was a 1907 graduate of Rush Medical College, Chicago, and was licensed that year. He had practiced in Minneapolis before coming to Indiana in 1943 to join the staff at the Caylor-Nickel Clinic, Bluffton, as a specialist in internal medicine. He had been active in the Wells County Medical Society, serving as secretary in 1949 and 1950 and as president this year. He was a member of Indiana State and American Medical Associations. Dr. and Mrs. Annis were preparing to leave for Florida to spend the winter with their son, J. W. Annis, M.D., 417 Waverly Place, Lakeland. Mrs. Annis will make her home there.



*your patients get high blood levels in 2 hours or less*

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# Erythrocin<sup>®</sup> STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

*disintegrates faster than enteric-coated erythromycin*

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## Erythrocin . . . *for faster absorption*

New tissue-thin *Filmtab* coating (marketed only by Abbott) starts to disintegrate within 30 seconds—makes ERYTHROCIN Stearate available for immediate absorption. Tests show Stearate form definitely protects drug from stomach acids.

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## Erythrocin . . . *for earlier blood levels*

because there's no delay from an enteric coating, patients get high, inhibitory blood levels of ERYTHROCIN in *less than 2 hours*—instead of 4-6 as before. Peak concentration is reached at 4 hours, with significant levels for 8 hours.

filmtab\*

## Erythrocin . . . *for your patients*

*Filmtab* ERYTHROCIN Stearate is highly effective against coccic infections . . . and especially useful when the infecting coccus is resistant to other antibiotics. Low in toxicity—it's *less likely to alter normal intestinal flora than most other oral antibiotics*. Conveniently sized (100 and 200 mg.) in bottles of 25 and 100. **Abbott**

\*TM for Abbott's film sealed tablets, pat. applied for.



# NEWS NOTES — from State and Nation

## AMA Directory Cards Should Be Returned Promptly

Every physician in the United States will receive a directory information card from the American Medical Association within the next few weeks. The information requested is to be used in compiling the new 1955 AMA Directory. Physicians are asked to fill in and return the card whether there has been any change in their status or not. This will make it possible for the AMA to furnish an accurate, current directory. The new edition—the nineteenth—will be delivered about the middle of 1955. There is no charge for publishing the data.

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**Dr. Robert M. Raber**, who recently completed two years naval service, has returned to Indianapolis where he is in practice with Drs. Harold M. Trusler, Thomas B. Bauer, and John M. Tondra at 408 Hume Mansur Building. Dr. Raber was on sea duty in the Pacific and was assigned to the plastic and reconstructive surgery section at San Diego Naval Hospital. He is a graduate of I.U. School of Medicine in 1944, interned at Oakland in the Navy and is a Board certified general surgeon. Dr. and Mrs. Raber live at 6036 Haverford Avenue, Indianapolis.

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**Dr. Chester A. Stayton**, Indianapolis, was elected to the Board of Directors of the American Cancer Society at the annual meeting October 17-22 in New York City. Dr. Stayton and Dr. Russell Malcolm, Richmond, vice-president and chairman of the executive committee of the Indiana division, attended the scientific sessions. Nine lay representatives of the Indiana division, headed by John G. Biel, Terre Haute, president, attended the meeting.

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**Organization of a council** of five general officers from the Army Medical Corps Reserve to advise The Surgeon General on matters re-

lated to medical reserve policies was announced November 1 by the Department of the Army. The first meeting at which the council was formed was held October 25. Council members are: Brig. Gen. Frank E. Wilson, director of the Washington office of the American Medical Association; Brig. Gen. Perrin H. Long, College of Medicine, State University of New York; Brig. Gen. Alexander Marble, Joslin Clinic, Boston; Brig. Gen. I. S. Ravdin, Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia; and Brig. Gen. Harold G. Scheie, assistant professor of ophthalmology, University of Pennsylvania, Philadelphia. Meetings of the council will be held twice a year.

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## ACS Sectional Meeting at Cleveland, February 21-24

Subsequent to the Clinical Congress of the American College of Surgeons, held November 15-19 in Atlantic City, plans for the sectional meetings were announced.

For this area, interest should be directed toward the Cleveland meeting, February 21-24, 1955. This will be a large four-day Sectional Meeting with separate specialty programs, hospital clinics and technical exhibits. Dr. Stanley Hoerr is the local chairman and specialty programs are under supervision of Dr. Allan C. Barnes, obstetrics and gynecology; Dr. Lorand V. Johnson, ophthalmology; Dr. Wilbert H. McGaw, orthopedic surgery; Dr. Fred W. Dixon, otolaryngology; Dr. Earle B. Kay, thoracic surgery; and Dr. George Austen, Jr., urology.

Two new features of this meeting will include a program of research problems presented from the Forum on Fundamental Surgical Problems at the 1954 Clinical Congress, and a special program for nurses and hospital personnel.

The complete program will be available soon and all physicians interested in surgical problems are urged to attend. Registration is not limited to Fellows of the College, who welcome the attendance of all surgeons.

### Indiana Roentgen Society Appoints Consultants

Physician members of the Indiana Roentgen Society have been named from several sections of the state to serve as consultants concerning the problems involved in the initiation and carrying out of routine chest x-ray examinations whether it be related to hospital admissions, hospital employees, food handlers or teachers.

The following members will be available for consultation with all interested parties: Drs. Richard Datzman, Fort Wayne; Arthur Hobbs, Evansville; John Campbell, Samuel Marchan, Harold Ochner, all of Indianapolis; Wallace Buchanan, South Bend; Joseph Weber, Terre Haute; and Morris Wertenberger, Richmond.

County medical societies should contact the consultant nearest to them.

Dr. John V. Thompson, Indianapolis, has returned from Europe where he appeared on the programs of two international medical meetings. He presented a paper on "Intrathoracic Rupture of the Trachea and Bronchi" in Barcelona, Spain at the International Congress on Diseases of the Chest, and later was one of the discussants of papers presented at the International Broncho-Aesophological Association meeting in Lisbon, Portugal. Dr. and Mrs. Thompson made a short tour of Europe before attending the meetings.

Dr. Kenneth L. Craft, Indianapolis, spoke on "Diagnosis and Treatment of Nasal Allergy" at the meeting of the Ear, Nose and Throat section of the District of Columbia Medical Society in Washington in October.

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### COOK COUNTY GRADUATE SCHOOL OF MEDICINE

#### INTENSIVE POSTGRADUATE COURSES STARTING DATES, SPRING 1955

**SURGERY**—Surgical Technic, Two Weeks, January 24, February 8

Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, March 7

Surgical Anatomy & Clinical Surgery, Two Weeks, March 21

Surgery of Colon & Rectum, One Week, March 1

Basic Principles in General Surgery, Two Weeks, March 28

General Surgery, One Week, February 14; Two Weeks, April 26

Gallbladder Surgery, Ten Hours, April 11

Fractures & Traumatic Surgery, Two Weeks, March 14

**GYNECOLOGY**—Office & Operative Gynecology, Two Weeks, February 14

Vaginal Approach to Pelvic Surgery, One Week, February 7

**OBSTETRICS**—General & Surgical Obstetrics, Two Weeks, February 28

**MEDICINE**—Two-Week Course, May 2

Electrocardiography & Heart Disease, Two Weeks, March 14

Gastroenterology, Two Weeks, May 16

Gastroscopy, Two Weeks, March 21

**RADIOLOGY**—Diagnostic Course, Two Weeks, January 3

Clinical Uses of Radio Isotopes, Two Weeks, April 25

**PEDIATRICS**—Intensive Course, Two Weeks, April 4

Clinical Course, Two Weeks, by appointment

Cerebral Palsy, Two Weeks, June 13

**UROLOGY**—Two-Week Urology Course, April 18

Ten-Day Practical Course in Cystoscopy every two weeks

TEACHING FACULTY—ATTENDING STAFF OF  
COOK COUNTY HOSPITAL

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. . . providing intensive individual psychotherapy in a residential setting.

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Director

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Ann Arbor, Michigan

### **Medical Director Named Mead Johnson Vice-President**

Directors of Mead Johnson and Company, Evansville, have named Dr. W. D. Snively, Jr. a vice-president, according to an announcement by Lambert D. Johnson, Sr., president of the nutritional and pharmaceutical firm.

Dr. Snively has been medical director of Mead Johnson and will retain that title in addition to his new one. He is in charge of liaison between his firm and the medical profession and plays a key role in guiding company policy on new product development and ethical marketing practices.

Dr. Snively, a native of Illinois, received his degree in medicine from Northwestern in 1938. From 1939 to 1941 he had a private practice in Rock Island and then served five years in the U. S. Navy during World War II. He has been with Mead Johnson since 1947.

Dr. J. J. Lind, a native of Utrecht, Holland and graduate of the University of Utrecht where

he received his medical degree in 1949, has established an office for the general practice of medicine in Mulberry at 135 South Main street. Dr. Lind came to the United States in September, 1951 on a fellowship to Kansas City General Hospital. He later spent one and a half years as resident physician in a North Carolina state hospital. Mrs. Lind is a native of Kansas. Dr. and Mrs. Lind and their two children spent the summer in Europe, returning in September to Franklin where they are living temporarily until housing can be found in Mulberry.

Dr. J. P. Elkins, who was recently released from Army duty after serving at Tripler hospital in Hawaii, has opened an office in the Southern Professional building, 234 East Southern avenue, Indianapolis, for the practice of obstetrics and gynecology. He is former chief of the obstetrical and gynecological service at the Camp Atterbury Army hospital. Dr. Elkins, is a 1947 graduate of the University of Virginia Medical School.

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Medical Director and Vice President**

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year tobacco heritage. Old Gold Filter Kings give you true tobacco taste in every single puff.

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never too tight—this easy draw filter makes every puff taste like a treat. **Doctors:** Today Old Gold Filter Kings are sold in most U. S. cities, and our distribution is expanding every day. If your city does not yet have Filter Kings, simply write to P. Lorillard Company, 119 W. 40th St., New York 18, N. Y., and special arrangements will be made to make them available to you.

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### **Deadlines for AMA June Meeting Announced**

The Council on Scientific Assembly of the American Medical Association has set December 15 as deadline for Section papers to be presented to the Atlantic City Meeting June 6-10 and January 10 as deadline for entries for the Scientific Exhibit.

Applicants should communicate with the Secretary or the Representative to the Scientific Exhibit of the Section in which they are interested. Further information may be obtained from the Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Exhibits which portray the latest developments in the fields of preventive medicine, industrial medicine, public health, research in any of these fields and teaching exhibits are wanted particularly.

### **Fellowships in Industrial Medicine Are Available**

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of industrial medicine. Any registered physician, graduate of a Class A medical school and with two years training in an accredited hospital, may apply. Experience in the armed forces or private practice may be substituted for one year of training.

The course includes two years of intensive training followed by one year of practical experience under supervision in industry.

Stipends during the first two years vary from \$3,000 to \$3,600 the first year and from \$3,400 to \$4,000 the second year. The third year's compensation comes from the industry being served.

Information may be obtained from the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati, 19, Ohio.

**Dr. Roy McKee**, graduate of the University of Louisville in 1943, is now associated with Dr. James G. Bledsoe in general practice at 319 South 14th Street, New Castle. Dr. McKee interned at Louisville General Hospital. He was a medical officer for three years with 17 months of the time spent in Korea. He was in general practice for one year in Winchester, Kentucky. Dr. and Mrs. McKee and their two daughters are residing at 1417 Church street.

### **Ciba Foundation, London, Announces Research Awards**

In view of the ever increasing importance of the medical, biological, and sociological problems of aging, the Ciba Foundation, a group for the promotion of international cooperation in medical and chemical research, is providing awards for papers on "Experimental Research Relevant to the Problems of Aging".

Five awards, of an average value of 300 pounds sterling, are available and announcement of awards will be made in July 1955.

Entries must be received not later than February 28, 1955, and will be judged by an independent panel of distinguished scientists who will advise the executive council of Ciba Foundation of their findings and will also have the power to recommend variation in the size and number of awards according to the standard of the entries. Decisions of the executive council will be final.

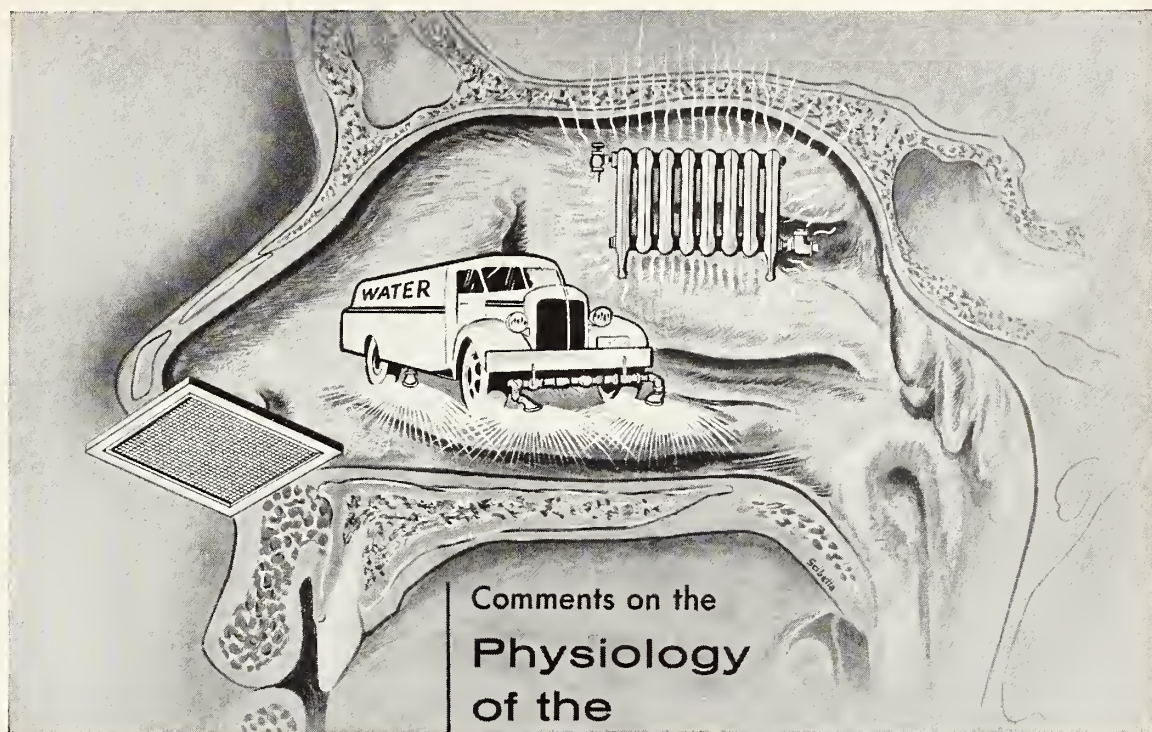
In making awards preference will be given to younger workers.

The work must be unpublished, but may be under consideration for publication, at the closing date for entries.

Papers may be in the candidates own language but a summary in English of not to exceed 500 words must be attached.

Name of the leading author, if there are co-authors, should be indicated; it is to him the award normally will be made.

Entries should be mailed to G.E.W. Wolstenholme, Director and Secretary to Executive Council, Ciba Foundation, 41, Portland Place, London, W. 1.



## Comments on the Physiology of the Upper Respiratory Tract

### THE NASAL CAVITY:

The main functions of the nasal cavity are conditioning and exchanging air between the atmosphere and the lungs, as well as smelling. Gross impurities are removed by the fine nostril hairs, and finer impurities are enveloped in the mucous secretion of the intranasal lining and carried away by ciliary action. The air is warmed to a degree approaching body temperature and humidified. About 500 cc. of air are taken in during an ordinary inspiration, totaling 12,000,000 cc. daily.

**In the common cold . . .** when hypersecretion and mucosal swelling interfere with the normal aeration pattern, when abnormal mouth breathing is resorted to as a distress measure, relief can be obtained promptly with topical application of Neo-Synephrine hydrochloride. This potent vasoconstrictor is usually well tolerated — produces practically no sting or irritation on application to mucous membranes — even in infants.

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1% Solution  
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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

October 24, 1954.

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Wm. Harry Howard, M.D.; W. L. Portteus, M.D.; Elton R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump and Robert Hollowell, attorneys; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

### Membership Report

Number of members October 23, 1954.....3,858\*  
Number of members October 23, 1953.....3,789  
Gain over last year ..... 69  
Number of members December 31, 1953....3,822

\* Includes

129 in military service (gratis)  
109 \$10.00 members (residents and interns)  
267 senior members  
63 members, dues remitted by Council  
2 honorary members

AMA dues paid: 1952...3,569; 1953...3,628\*\*;  
1954...3,606.

\*\* Includes 420 members permanently exempted in 1952.

### Headquarters Office

Mr. Amick reported on his calls during the past month, telling of the situation existing in Vincennes, and upon motion of Drs. Portteus and Howard, the secretary was instructed to refer this matter to the Committee on Medical Education and Hospitals with the request that they contact the Joint Commission for clarification.

Mr. Bush reported on his activities covering the recording and society meetings, and the booth at the state convention.

### Legislative Matters

#### National

The secretary reported the announcement that President Eisenhower has renewed his appeal for support of voluntary health insurance.

#### Local

The secretary reported that two bills, one to create an Indiana Board of Ophthalmic Dispensers and the other concerning the education and training of children who are handicapped by a hearing deficiency had been presented to the association for its approval and that they would be discussed in a meeting of the Council.

### Annual Convention, Murat Temple, Indianapolis, October 24-27, 1954

By consent, the bills for entertainment by MacMurray, Ethel Smith and the Indianapolis Symphony Orchestra were approved.

President Howard's address was approved by the committee with minor changes.

The remarks of Mrs. Harry C. Harvey, president of the Woman's Auxiliary, were approved with minor changes.

The secretary gave a review of the general convention arrangements.

### Organization Matters

The secretary read a letter from the St. Paul Mercury Indemnity Company and reported on his conversation with several members regarding the tactics of the agents in renewing their malpractice insurance policies.

The secretary read the conclusions of the special Council committee regarding the Portteus unity plan.

A letter was read from Mutual Medical Insurance in which the proposal made to the Auxiliary for instituting an Auxiliary committee, the letter being in reply to previous action of the Executive Committee, was approved by consent and the secretary was instructed to notify the Auxiliary of the committee's approval of the organization of such a committee.

The secretary read a telegram which he had received from the Council of the Wisconsin State Medical Society, informing the committee that copies had been sent to the president, president-elect, and the executive vice-president of the Blue Shield Plan and to Dr. W. U. Kennedy who was to represent the plan at a meeting concerning this matter.

### The Journal

*Report on advertising* was accepted by consent:

Total, November, 1954.....\$3,081.30  
Total, November, 1953..... 2,271.48  
Net gain ..... 809.82

The secretary read a letter from the C. E. Pauley Company in which the association was informed that effective October 1, 1954, there would be a 4% increase in the publication cost of *THE JOURNAL*. Increase approved on motion of Drs. Howard and Clarke.

Statements of receipts and expenditures for *THE JOURNAL* for August and September were approved.

There being no further business, the Committee adjourned to meet again at 11:00 a.m., Sunday, November 14, in the conference room at the I. U. Student Union Building, on the Medical School campus, Indianapolis.

**INDIANA STATE MEDICAL ASSOCIATION****The Council**

(Indianapolis Session, 1954)

**First Meeting**

The Council convened at 3:10 p.m., Sunday, October 24, 1954, in the Student Union Building, Indiana University Medical Center, Indianapolis, with Dr. Elton R. Clarke, the chairman, presiding. Roll call showed the following present:

**Councillors:**

First District-----Minor Miller, Evansville  
 Second District-----A. G. Blazey, Washington  
                               J. H. Crowder, Sullivan,  
                               councilor-elect  
 Third District-----William H. Garner, New Albany  
 Fourth District-----J. E. Dudding, Hope  
 Fifth District-----M. C. Topping, Terre Haute  
                               V. Earle Wiseman, Greencastle,  
                               alternate  
 Sixth District-----W. U. Kennedy, New Castle  
                               Harry P. Ross, Richmond,  
                               alternate  
 Seventh District-----Lester D. Bibler, Indianapolis  
                               Charles A. Jones, Franklin,  
                               alternate  
 Eighth District-----T. R. Hayes, Muncie  
                               Gordon B. Wilder, Anderson,  
                               alternate  
                               Guy A. Owsley, Hartford City,  
                               councilor-elect  
 Ninth District-----Wemple Dodds, Crawfordsville  
                               H. E. Klepinger, Lafayette,  
                               alternate  
 Tenth District-----James P. Vye, Gary, alternate  
 Eleventh District-----Elton R. Clarke, Kokomo  
 Twelfth District-----Maurice Glock, Fort Wayne  
 Thirteenth District-----Kenneth L. Olson, South Bend  
                               G. O. Larson, LaPorte,  
                               alternate

**Officers:**

Wm. Harry Howard, Hammond, president  
 Walter L. Porteus, Franklin, president-elect  
 Roy V. Myers, Indianapolis, treasurer

**Journal:**

Frank B. Ramsey, Indianapolis, editor of THE JOURNAL  
 A. W. Cavins, Terre Haute, Associate Editor of  
 THE JOURNAL

**Executive Committee:**

James W. Denny, Indianapolis, chairman  
 E. H. Clauser, Muncie  
 Albert Stump, attorney  
 Robert Hollowell, attorney  
 Robert J. Amick, field secretary  
 Kenneth W. Bush, field secretary  
 J. A. Waggener, executive secretary

**Delegates and Alternates to A.M.A.:**

Cleon A. Nafe, Indianapolis, delegate  
 E. S. Jones, Hammond, delegate  
 Alfred Ellison, South Bend, delegate  
 Wendell C. Stover, Boonville, delegate

**Guests:**

R. H. Hansell, Indianapolis, chairman, Committee  
 on Convention Arrangements  
 J. William Wright, Sr., Indianapolis, co-chairman,  
 Legislative Committee  
 John D. VanNuys, Indianapolis, Dean, Indiana Uni-  
 versity School of Medicine  
 Paul R. Tindall, Shelbyville, secretary, Indiana  
 State Board of Medical Registration and Exami-  
 nation  
 Will A. Thompson, Liberty  
 John J. Flick, Indianapolis

On motion of Drs. Bibler and Dudding, minutes of the July 25, 1954, meeting of the Council were

approved as printed in the September, 1954, JOURNAL.

**REMARKS OF DOCTOR VAN NUYS**

DR. JOHN D. VAN NUYS, Dean, Indiana University School of Medicine:

"Mr. President and members of the Council: I regard it as an honor and privilege to be invited to appear before you to give you a brief report on the operation of the School of Medicine, and what I give you will be quite brief and a group of unrelated facts.

"On Monday of this last week the Association of American Medical Colleges met at French Lick. We attended those meetings for three days, and then for the last three days we have had a formal inspection of the school by members of the Council on Medical Education of the American Medical Association and by the Association of American Medical Colleges. This is the first inspection the school of medicine has had since 1934 and I, of course, was somewhat concerned, realizing that a great deal was at stake and hoping that we would qualify as a class A institution. I am very pleased to tell you that they did tell me late yesterday afternoon that they were going to recommend to the Council that we remain on the accredited list.

"There are a number of interesting things, I think, that came out of the inspection: a number of the departments were termed strong departments; they were pleased with the research program; they were pleased with the building program. They were particularly pleased with the relationship that has existed between the State Medical Association and the School of Medicine and the help that you men have given in this educational program, which they described as quite unique.

"They were quite impressed with the job that Jim Denny and his committee have done. They wondered why Indiana University School of Medicine has received \$29,000.00 more in support from physicians and alumni in one year than any other of the 79 schools of the United States. I told them that was purely the initiative and the push that has been given by the men of this committee, with the backing of the House of Delegates of the Association.

"They were further impressed by the fact that you hold your meetings here and that you have continued to do so,—the Council and the Executive Committee, and now the House of Delegates. They told me that they had visited a school as recently as six weeks ago where there were no relationships between the state medical society and the state university school of medicine. I think it was one of the high points of the visit, describing that relationship and the support that has been given.

"I said I was going to talk on unrelated facts. One thing has to do with the construction of the new medical science building. As you know, the last legislature made an appropriation for beginning that building and we have asked for additional funds now to complete the building. We have purchased the necessary land and have removed the houses behind the old medical school for the construction of the new medical science building. We are out for bids on that structure now and hope that the contract will be let not later than the 20th of November and that construction will begin immediately. As you know, this will bring the first year of medicine and the first year of dentistry to Indianapolis, something that has been envisioned for 51 years, and the investigating team felt that this would be a very strong factor in strengthening the teaching program of the school. That building with its equipment will cost seven million dollars, and to understand its size, it is 15 per cent less than twice the cubage of the building in which we are now



meeting. It will be a large building and can accommodate the faculty of the staff of medicine, the first two years of dentistry, and the basic nursing program. Of the current General Assembly we have asked for the money to complete the building and have had the concurrence of the Budget Committee, so we feel that it will be forthcoming. We have asked for additional money for housing, non-income-producing housing, and that will be for student nurses largely. We were handicapped this year, I don't know whether this is a general experience or not, but we have had 107 freshmen in the degree course in nursing and 97 freshmen in the diploma course in nursing; over 200 freshmen nurses, and we had to turn down applicants because we just couldn't house them. We have 30 some senior nurses living off the campus in housing that we try to supervise under university regulations, and we have had 22 living in the gymnasium at the training school, and unless we expand our housing facilities, we will not be able to do the job for the state in producing nurses for private nursing and nurses who will be trained in surgical techniques, obstetrics, pediatrics and a number of other specialties. I thought you would be interested in our requests that are going into the General Assembly.

"Another request that we have does not involve the General Assembly, but is under consideration by the University, and that is remodeling of the children's hospital. That will be done largely with funds available from the Riley Memorial Association. About a million and a half dollars of remodeling and refurbishing is necessary for that building.

"I want to say another thing that impressed the inspection team, and I hadn't realized this too much, but I want to comment on the extreme interest and generosity of our president and our Board of Trustees in relation to the School of Medicine. I am sure their great interest is rather unique in American medicine and in American universities. While the total budget of the University has been raised 2.6 since 1947, the direct operating budget of the School of Medicine, that part which the University puts into the operation of the School of Medicine, has increased 5½ times, and our enrollment has increased only 16%, and the Bloomington enrollment has increased 300%, so I think it does show that the trustees of the University have been generous to the point at which they can be generous in the financial support of this school.

"The inspectors were interested in the research program, which at the time of their last inspection the annual expenditure was \$5,800.00. In 1946 it was \$11,000.00, and in 1953, \$454,586.00, and that money has come from outside sources and does not represent a tax burden upon our people.

"A year ago I came before you for permission to revise the geographical full-time practice plan here at the school. Previous to that you had endorsed the plan which placed an income ceiling on practitioners who are in the various medical and surgical specialties and who confine their activities to the University Hospitals and those hospitals affiliated with the School of Medicine. That income ceiling worked this way. A person was guaranteed X number of dollars, regardless of whether he saw a private case or not. If he saw a private case then he would either keep the fee and report it to the business office and that would be deducted from his monthly check, or he could turn in the fee and be paid his monthly stipend. There were defects in that kind of arrangement and one of the most alarming things that could have crept into the picture, and I assure you did not, would be for the dean of the school to say to the man who had been guaranteed \$15,000 and only did \$700.00 in private practice during the year, Well, you get busy and next year you collect

\$14,000 because I need that money to put into physiology, anatomy or other basic sciences. Last year with three less men, our total patient days for the geographical full-time men was 6,120 and the total this year with three more men is 7,462, an increase of 1,300 under the new plan. This is included in the 30,000 private patient-days in the University hospitals for the year. So the geographical full-time men account for 25% of the private work done in the University hospitals. A total of 261 physicians, private physicians, have participated in the private patient program here during the last five years. Some have not had patients in every year. Our total bed occupancy, or total patient days, for the last year was 147,000. So, of the 147,000 total, 30,000 were private patient days and 7,400 of these were for the geographical full-time men. I promised that I would bring you this report. To my certain knowledge, no one has shirked or avoided his responsibility for ward rounds or other teaching duties. None of the staff has failed to attend the important national meetings that are important in representing the school.

"I want to tell you that without your very generous and warm support and the direct help you have given, it would have been quite difficult to develop the school program along modern lines. I see a great future for the school and I think we agree that Indiana needs a strong school of medicine. We must offer opportunities here to Indiana boys and girls equal to opportunities found anywhere. We have one of the lowest tuition rates of any medical school in the United States, \$310.00 per year. The Board of Trustees wants to adhere to the policy of low fees. We should not keep deserving and promising people out of the profession merely because they cannot easily afford a medical education. If we cut our enrollment I have no doubt that there would be 15 or 20 Indiana boys who would be denied the privilege of studying medicine and entering our profession due to the fact that they do not have the money to go to an out-of-state school. You have been very generous in your support, you have been helpful in advice, and I hope that this pleasant arrangement will continue for many, many years. Thank you."

On motion of Drs. Glock and Kennedy the Council went "on record as highly commending Doctor VanNuys for the fine job that he is doing for the Medical School and also for his fine spirit of cooperation with the medical society."

#### District Meetings

Dr. Miller, chairman of the committee appointed to study the matter of conflicts in district meeting dates, reported that he had not been too successful in getting dates set for district meetings. However, all but four districts have set their meeting dates as follows:

First District.....Tell City, September 15, 1955  
 Second District.....Date to be set after first of the year  
 Third District.....New Albany. Date not yet set.  
 Fourth District.....Batesville, May 4, 1955  
 Fifth District.....Turkey Run, May 11, 1955  
 Sixth District.....Brookville, April 22, 1955  
 Seventh District.....Indianapolis, May 10, 1955  
 Eighth District.....Portland, May 25, 1955  
 Ninth District.....Date will be set after January 1  
 Tenth District.....  
 Eleventh District.....Kokomo, May 18, 1955  
 Twelfth District.....Kendallville, May 18, 1955  
 Thirteenth District.....Westville, November 17, 1954

(Continued on Page 1428)



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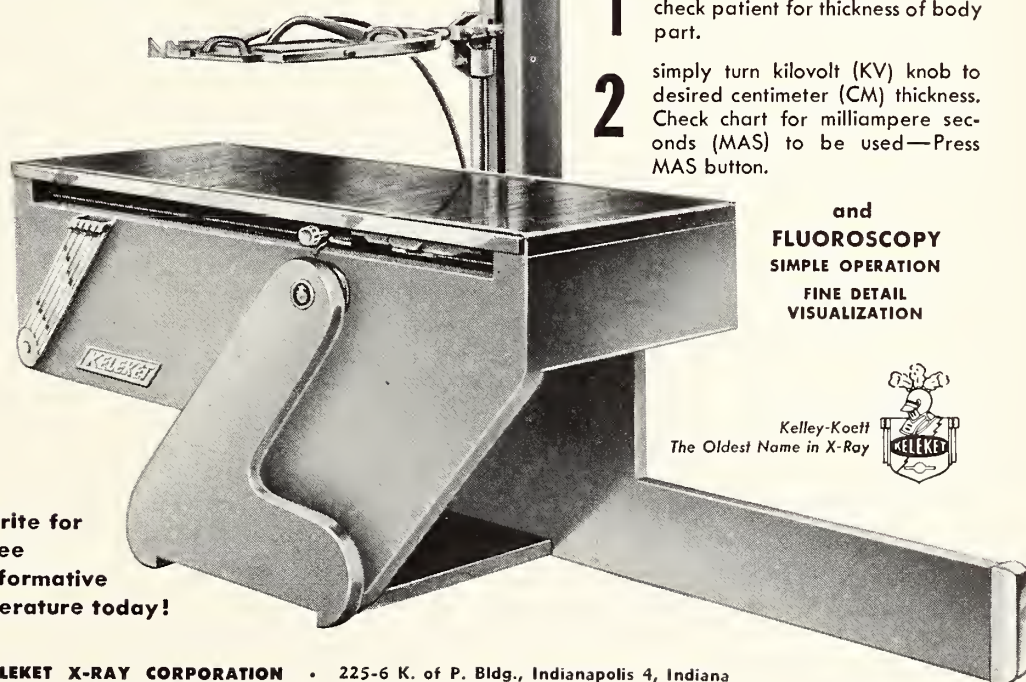
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## Unfinished Business

1. *Dr. Hansell, Convention Arrangements Chairman*, reported that his committee had made arrangements very similar to those in the past for the 1954 annual session, with golf tournament and trap shoot scheduled for Monday, October 25, scientific meetings, class, fraternity and special luncheons on Tuesday, October 26, and general scientific meeting on Wednesday morning, October 27, with section meetings Wednesday afternoon, and the annual banquet Wednesday evening.

2. *Legislative matters* were reviewed by Dr. J. William Wright, Sr., co-chairman of the Legislative Committee, in the absence of Dr. Hugh S. Kuhn, co-chairman. On motion of Drs. Blazey and Dudding the Council accepted the Legislative Committee's report and commended Dr. Kuhn and Dr. Wright on the excellency of their report.

3. *Portteus Unity Plan*. Dr. Olson, chairman of the special committee of the Council appointed to study the recommendation that the annual convention of the Association be extended an extra day, announced that before his committee met, the officers of the various sections and the general practice and specialty groups of the state were written and asked their opinion of adding another day to the state medical association convention. Following that, the special committee met, with Dr. Bibler acting as secretary. Dr. Olson presented the following report from the committee:

This committee met at 10 A.M. on Sunday, October 10, 1954, at the Student Union Building, Indianapolis, Indiana. The following doctors were present: representing their specialties, P. L. Stiers, M.D.—Medicine; Dale Pyle, M.D.—Pediatrics; J. A. Robb, M.D.—Radiology; E. B. Boyer, M.D.—Trudeau Society; J. Wm. Wright, Jr., M.D.—Ear, Nose and Throat; Frank Green, M.D.—General Practice; O. T. Scamahorn, M.D.—General Practice. Also present were Elton Clarke, M.D., Chairman of the Council; Walter Portteus, M.D., President-elect of the Indiana State Medical Association; James Waggener, executive secretary. Members of the committee present were Doctors Kennedy, Olson and Bibler. Dr. Olson presided and Dr. Bibler acted as secretary. Dr. Olson opened the meeting and Dr. Portteus opened the discussion relative to the advisability of extending the State Medical Convention one additional day. Dr. Portteus raised the question, if the State Medical Association was losing grounds as the Basic Medical Organization in Indiana due to too many medical tangents. He also offered the idea of joint meetings of the various sections which had small attendance.

Mr. James Waggener stated that the present trend is to get away from so many medical meetings.

Dr. Scamahorn stated that the Indiana Academy of General Practice had made commitments for 1955, but would be glad to cooperate on any future arrangements. He also asked the question: "Will the specialty groups lose their identity in such an arrangement?" Mr. Waggener suggested that each section might have their own meeting just prior or after the Annual State Medical meeting.

Dr. Frank Green stated that the specialty groups could meet prior to the State Medical meeting. He stated he would be in favor of anything to help the State Medical meeting.

Dr. William Wright asked the question: "Would there be additional financial expense?" Mr. Wag-

gener answered the only additional expense would be the rental of the Convention Hall. Dr. Wright stated they would be in favor of a joint meeting. Dr. Boyer stated he did not think his meeting could be incorporated. He also raised the question if attendance would be increased to the Section meetings with such an arrangement. Dr. Boyer further stated he would be interested in having joint meetings with other groups and would be glad to cooperate. Dr. Robb stated that the X-ray Section could integrate an x-ray program with the State Medical meeting, however, their annual meeting is usually in the Spring. Dr. Dale Pyle stated that there are about 40 to 50 pediatricians in the state. They usually have a Spring meeting with national speakers and attendance is not very good due seemingly to lack of interest. Their annual meeting is in the Fall in Chicago, and lasts for five days. He also stated that doctors in northern Indiana who are not graduates of Indiana University show little interest in attending the State Meeting. However, he states his group is willing to cooperate and would suggest one afternoon and evening reserved for Section meetings. He does not desire to increase the length of time of the State Meeting.

Dr. Stier stated that there were only 20 to 25 men attending his Section meeting and questions the advisability of adding a day to the program. However, he stated they would be glad to cooperate.

Dr. Elton Clarke stated that interviews with various doctors throughout the state expressed the thought they did not wish to lengthen the time of the State Medical meeting. Dr. Kennedy stated he would support anything for a unity plan. Dr. Wright stated that the Academy or College meetings should not affect the policy of the State Medical Association.

There was no adverse criticism of the State Medical meetings as they are at this time. Sunday or Wednesday were the days best recommended for Section meetings. Following luncheon the committee met in executive session and the following items were noted.

1. There was universal objection to adding an additional day to the Indiana State Medical Annual Convention.
2. All men present expressed willingness to go along with integrations of Section programs.
3. It was recommended that no other meetings be held to distract Section meetings.
4. There should be closer integration of the various specialty groups to increase attendance at Section meetings.
5. Many specialty groups expressed the opinion they did not desire to lose their identity by meeting in conjunction with the State Medical Association Convention.
6. It is recommended that the question of program and length of time of the State Medical Association Convention be referred to a subsequent committee for further study.

On motion of Drs. Olson and Bibler the Council accepted this report.

4. *Amendments to By-laws to be presented to House of Delegates as result of action taken by Council at previous meetings:*

a. Amendment to By-laws on staggered committees. (See page 1452, House of Delegates minutes.)

b. Amendment to By-laws, adding psychiatrist to membership of Board of Appeals. (See page 1452, House of Delegates minutes.)



**New Business**

1. *American Medical Education Foundation.* Dr. Denny, chairman of the Committee on Medical Education and Hospitals, called attention of the Council to the following matters:

a. The postgraduate seminar held at Norways Sanatorium, Indianapolis, last spring, which was very successful, and which will be repeated again next spring.

b. The growth of the committee's tape recording business. Members are invited to notify headquarters office if they wish a scientific medical meeting recorded.

c. To date, this year, the 1954 grant for the Indiana University School of Medicine amounted to \$49,367.00. Of that, up to the first nine months of this year, Indiana physicians have sent in \$22,000.00. To date the total from doctors in the state is \$128,000.00. This year, the National Foundation, for the first time, has gone over the two million dollar mark, \$2,176,000.

d. The fine work being done by Mrs. Frank Gastineau, Indianapolis, national chairman of AMEF for the Woman's Auxiliary.

2. *Matters referred to Council by Executive Committee:*

a. *Increase in JOURNAL publication printing costs.* Letter from the C. E. Pauley & Co., Inc., publishers of THE JOURNAL, was read, informing the Association of the necessity of increasing printing costs 4% or \$.75 per page as of October 1, 1954. On motion of Drs. Dudding and Hayes, the Council endorsed this increase in printing costs.

b. *Resolutions Nos. 5, 6 and 7.* The chairman announced that these resolutions would be discussed later in the agenda.

3. *Committee on Indiana Inter-Professional Health Council.* On motion of Drs. Kennedy and Garner, the Council reelected Drs. Herman T. Combs, Evansville, and Donald E. Wood, Indianapolis, members of this committee for 1954-55.

4. *Election of JOURNAL Editors.* On motion of Drs. Portteus and Glock, Dr. Frank B. Ramsey, Indianapolis, was reelected editor of THE JOURNAL for 1955.

On motion of Drs. Blazey and Vye, the present associate editors were reelected for 1955 as follows:

A. W. Cavins, Terre Haute  
Lall G. Montgomery, Muncie  
Stephen L. Johnson, Evansville  
David A. Bickel, South Bend

5. *Resolutions to be presented to the House of Delegates:*

a. *Amendment to By-laws on staggered committees,* to be referred to House with the approval of the Council, by consent.

b. *Amendment to Constitution to provide for filling vacancies on the Council,* approved by consent.

c. *Third District Medical Society resolution,* asking that insurance companies and corporations in formulating their insurance policies or health insurance plans abide by the rules and regulations of the American Medical Association, approved by the Council on motion of Drs. Olson and Miller.

d. *Resolution from Allen county on essentials of an approved internship—*on motion of Dr. Blazey, seconded by several, approved by Council.

e. *Resolution from Madison county on sponsoring an essay contest—*approved on motion of Drs. Kennedy and Blazey.

f. *Resolutions Nos. 5, 6 and 7, page 113 of the Handbook, from Porter county—*on motion of Drs. Dodds and Miller were referred to the House of Delegates without recommendation.

6. *"Hearing-handicapped child" bill.* On motion of Drs. Blazey and Olson, this bill was referred to the House of Delegates without recommendation.

7. *Ophthalmic dispensers licensing bill.* Dr. John J. Flick, Indianapolis, representing the Indiana Academy of Ophthalmology and Otolaryngology, explained that this is essentially a bill providing for the licensing of everyone who dispenses optical goods in Indiana, a bill to standardize ophthalmic dispensing. On motion of Drs. Blazey and Glock, the bill was referred to the House of Delegates for consideration without recommendation of the Council.

**Date for Midwinter Council Meeting**

The Council set Sunday, January 16, 1955, as the date for the midwinter meeting, on motion of Drs. Garner and Glock.

There being no further business, the Council adjourned to meet again on Wednesday, October 27, 1954, immediately following the adjournment of the House of Delegates.

**THE COUNCIL**

(Indianapolis Session, 1954)

**Second Meeting**

The Council met for its second meeting immediately following adjournment of the House of Delegates, Wednesday morning, October 27, 1954, in the Little Auditorium, Athenaeum, Indianapolis, with Dr. Elton R. Clarke, chairman, presiding.

Eleven councilors, four alternate councilors, the president, the president-elect, the treasurer, the executive secretary, a member of the Executive Committee, and one association attorney were present.

No business appearing, the Council adjourned.



# Proceedings of the House of Delegates 1954 Annual Convention — Indianapolis

October 24, 25, 26 and 27, 1954

The House of Delegates convened in Room M-124, Student Union Building, Indiana University Medical School campus, Indianapolis, at 6:30 p. m., Sunday, October 24, 1954, and again at 7:30 a. m., Wednesday, October 27, 1954, in the Little Auditorium of the Athenaeum, Indianapolis, with the president, Dr. Wm. Harry Howard, Hammond, presiding.

Rabbi Ephraim Bennett of Indianapolis led the invocation at the opening of the first meeting.

## REPORT OF REFERENCE COMMITTEE ON CREDENTIALS

On motion of Drs. Nay and Black, attendance slips signed by the delegates were accepted in lieu of a roll call at the first meeting, the chairman of the Reference Committee on Credentials, Dr. W. C. Stover, reporting 127 delegates present.

At the second meeting, roll call showed 136 delegates present.

## REPORT OF REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

At the second meeting of the House of Delegates, in the absence of Dr. A. P. Hauss, chairman of the Reference Committee on Rules and Order of Business, Dr. Frank Green, member of the committee, reported that the committee had ruled that there should be a roll call at the second meeting of the House, and for this convention only, that late resolutions could be brought in if the House agreed by a two-thirds vote of those present.

On motion of Drs. Nafe, Green, Tindall and Good, the report of the Reference Committee on Rules and Order of Business was accepted.

The chairman read Chapter XVII, Section 1, of the Bylaws and Article XIV of the Constitution regarding amendments to the Bylaws and the Constitution.

## IN MEMORIAM

The House stood in memory of the following physicians who were members of the House of Delegates, or who had served the Association in an official capacity, and who had died since the 1953 annual session:

HENRY F. BECKMAN, Indianapolis. Chairman of Committee for the Study of Puerperal Mortality, 1936; chairman of Sub-committee to Study Maternal Morbidity and Mortality Rates for Indiana, 1937 through 1941.

CLAUDIUS L. BOYD, Vincennes. Delegate from Knox County 1944, 1945 and 1946. Secretary,

Knox County Medical Society 1908, 1941 through 1946; member, Committee to Study Cultists and Irregular Practitioners, 1938 through 1943.

W. DANIEL BRETZ, Huntingburg. Secretary, Dubois County Medical Society, 1920 through 1923.

ERNEST P. BUCKLEY, Jeffersonville. Secretary, Clark County Medical Society, 1917 through 1920, 1930, 1941, 1942, 1943; vice-chairman 1941, and chairman, 1942 and 1943, Section on Anesthesia; member, Committee on Secretaries' Conference 1943 and 1944; member, Committee on Convention Arrangements, 1945 and 1947; delegate from Clark County Medical Society, 1942, 1943, 1944, 1947 and 1949.

EUGENE L. BULSON, Fort Wayne. Member of Committee on Scientific Work, 1932; chairman, Committee on Lye Burns in Children, 1933; member of Committee on Lye Burns in Children, 1934 through 1936; secretary of the Section on Ophthalmology and Otolaryngology, 1937 and 1938; member of Committee on Conservation of Vision, 1944, 1945 and 1946, and chairman of committee in 1947 and 1948; member of Editorial Board, 1946 and 1947; member of Committee on Historical Exhibits, 1949; member of Committee on Instructional Courses, 1953 and 1954.

JAMES C. CARTER, Indianapolis. Member, State Division of Public Health Liaison Committee to Deal with Social Security Act, 1936 through 1940; member of Sub-committee to Study Maternal Morbidity and Mortality Rates for Indiana, 1938 through 1940; member, Advisory Committee to Bureau of Maternal and Child Health of the Indiana State Board of Health, 1941 through 1944 and 1946.

GEORGE A. COLLETT, Crawfordsville. Delegate from Montgomery County, 1945 and 1946; secretary, Montgomery County Medical Society, 1928 through 1930, and 1933; member of Committee on Secretaries' Conference, 1929; secretary, Surgical Section, 1930, 1931, 1932; vice-chairman, Surgical Section, 1944; chairman, Surgical Section, 1945; member, Committee on Postgraduate Study, 1931 and 1933; member, Committee on Prevention of Traffic Accidents, 1935 and 1936; member, Liaison Committee with Indiana Crippled Children's Bureau, 1940 through 1943; alternate delegate to the American Medical Association, 1946.

NELSON B. COMES, Mulberry. Member, Committee on Veterans Affairs and Rehabilitation, 1953.

ERNEST M. CONRAD, Anderson. Councilor from the Eighth District, 1923 and 1924.

HOMER B. GABLE, Monticello. Delegate from White County Medical Society, 1944; secretary, White County Medical Society, 1917 through 1945.

HERMAN C. GROMAN, Hammond. Secretary, Lake County Medical Society, 1910.

GERALD W. GUSTAFSON, Indianapolis. Member of Committee on State Fair, 1936; member of Advisory Committee to Bureau of Maternal and Child Health of Indiana State Board of Health,

- 1945 and 1946, and chairman of committee in 1947; chairman of Committee on Maternal and Child Health, 1948, 1949, 1950, and member of the committee in 1952 and 1953.
- JAMES M. HICKS, Huntington. Secretary, Huntington County Medical Society, 1937 and 1938.
- LAURENCE E. JEWETT, Wabash. Secretary, Wabash County Medical Society, 1908, 1909, 1910, 1912 through 1914.
- CHARLES E. LINTON, Medaryville. Secretary, Pulaski County Medical Society, 1912 through 1917; delegate from Pulaski County Medical Society, 1934, 1946 and 1947.
- LOUIS C. LUKEMEYER, Huntingburg. Member of Committee on Medical Economics, 1916; secretary, Dubois County Medical Society, 1926 through 1936.
- FRANCIS A. MALMSTONE, Griffith. Member, Committee on Rural Medical Care, 1945; member, Centennial Celebration Committee, 1946 and 1947.
- WILBUR C. MATHEWS, Kentland. Delegate from Jasper-Newton County Medical Society, 1936; secretary, Jasper-Newton County Medical Society, 1936 through 1940.
- WILLIAM MCCOOL, Evansville. Member of Committee on Industrial and Civic Relations, 1920.
- HARLEY S. McKEE, Greensburg. Secretary, Decatur County Medical Society, 1932, 1933, 1944 through 1946; member, Committee on Old Age Dependency, 1937; delegate from Decatur County Medical Society, 1936, 1940, 1941, and 1946.
- OLIVER C. NEIER, Indianapolis. Member of Committee on Public Policy and Legislation, 1909-1910.
- ALONZO C. NEWBY, Sheridan. Member, Committee on Physicians' Welfare, 1914-1915.
- JACOB T. OLIPHANT, Farmersburg. Delegate from Sullivan County Medical Society, 1934 through 1941; third vice-president, 1924; member, Committee on Study of Health Insurance, 1933; member, Committee on Graduate Education, 1936; member, State Board of Health Liaison Committee to Deal with Social Security Act, 1939; member of Medical Relief Committee, 1940 through 1943; President-elect, 1943; President, 1944; member of Executive and Budget Committees, 1943 and 1944; chairman of Budget Committee, 1945; member of Committee on Indiana Inter-Professional Health Council, 1944; member of Committee on Establishment of Board of Certification for the General Practice of Medicine, 1946; chairman of Section on General Practice, 1946; chairman of Grievance Committee, 1950; member of Committee on Chronic Illness, 1950 and 1952.
- G. IRENE POLHEMUS, New Albany. Delegate from Floyd County Medical Society, 1944; secretary, Floyd County Medical Society, 1941 through 1944; member, Centennial Celebration Committee, 1945 through 1947.
- ISADOR J. RAPHAEL, Evansville. Member, State Board of Health Liaison Committee to Deal with Social Security Act, 1938.
- JEWETT V. REED, Indianapolis. Member, Committee on Pathology, 1907 through 1911; member, Committee on Medical Research and Postgraduate Work, 1912; member, Committee on Scientific Demonstrations, 1914; chairman, Committee on Scientific Work, 1927; chairman, Committee on Civic and Industrial Relations, 1931; member, Insurance Committee, 1932.
- AMOS H. RHODES, Princeton. Secretary, Gibson County Medical Society, 1921 through 1923; member, Committee on Industrial and Civic Relations, 1925.
- FLOYD T. ROMBERGER, Lafayette. Member, Committee on Anesthesia, 1926; chairman, Committee on Postgraduate Study, 1927, 1928 and 1929; Councilor of Ninth District, 1930 to 1946; chairman of the Council, 1940 through 1945; member, Committee on Scientific Work, 1932; Editorial Board member, 1933 through 1939; chairman, Section on Anesthesia, 1935; member, Committee on Inter-Allied Professional Health Council, 1938, 1941 through 1944; member, Budget Committee, 1942 through 1947; chairman, Budget Committee, 1948; member, Executive Committee, 1943 through 1947; President-elect, 1946; President, 1947; member, Scholarship Committee, 1947.
- ERNST L. SCHAIBLE, Gary. Delegate from Lake County Medical Society, 1937 through 1939, and 1949; member, Committee on Automobile Insurance, 1925; member, Township Trustees Liaison Committee, 1936; member, Committee on Public Policy and Legislation, 1937 and 1938.
- ROBERT A. SMITH, New Castle. Secretary, Henry County Medical Society, 1930 through 1933; vice-chairman, 1947, and chairman, 1951 and 1952; Section on Ophthalmology and Otolaryngology; member, Committee on Conservation of Vision, 1949 and 1950; member, Committee on Hard of Hearing, 1953.
- WILLIAM M. VARBLE, Jeffersonville. Delegate from Clark County Medical Society, 1934, 1940 and 1941; member, Committee on Public Policy and Legislation, 1907-1908.
- IRA M. WASHBURN, Rensselaer. Second vice-president, 1921.
- J. H. WEINSTEIN, Terre Haute. Councilor of Fifth District, 1907 through 1918; 1922 through 1928; member, Committee on Prevention of Venereal Disease, 1910-1911; member, Committee on Hospital Standardization, 1920 through 1926, and chairman in 1924; President-elect, 1932; President, 1933; member, Budget Committee, 1932 through 1934; member, Executive Committee 1933; member, Public Relations Committee, 1934 through 1936; member, Committee on Study of Health Insurance, 1938; member, Liaison Committee with Indiana Crippled Children's Bureau, 1939 through 1944; member, Medical Economics Committee, 1945 and 1946.

## MINUTES OF THE MEETINGS

held October 18 and 21, 1953, at French Lick, were approved as published in the December, 1953, JOURNAL, on motion of Drs. Daniels and Denny.

## INTRODUCTION OF GUESTS

ELMER HESS, M.D., Erie, Pennsylvania, president-elect of the American Medical Association;

DAVID K. HEUSINKVELD, M.D., Cincinnati, president-elect of the Ohio State Medical Association;

ARKELL M. VAUGH, M.D., Chicago, president of the Illinois State Medical Society;

CLYDE SPARKS, M.D., Ashland, Kentucky,



president of the Kentucky State Medical Association;

R. L. SENSENICH, M.D., South Bend, past president of the American Medical Association and the Indiana State Medical Association;

J. P. SANFORD, Louisville, executive secretary of the Kentucky State Medical Association;

JOHN S. DeTAR, M.D., Milan, Michigan;

GEORGE L. THORPE, M.D., Wichita, Kansas;

DANIEL McKINNEY, president, AMA Student Medical Association; and

LEON BLOCK, treasurer, AMA Student Medical Association.

### ELECTION OF PHYSICIAN OF THE YEAR

DR. ARTHUR E. STINSON, of Athens, Fulton county, was elected recipient of the Physician of the Year Award for 1954.

### AMENDMENT TO CONSTITUTION PROVIDING FOR FILLING VACANCIES ON THE COUNCIL

The following amendment to Article IX of the Constitution, introduced at the 1953 annual convention, and published twice in *THE JOURNAL* during the past year, was passed by the House:

"That Article IX of the Constitution be amended by adding an additional section to be numbered Section 9 to read:

'In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor. In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the executive secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call.'

"And that the Article be further amended by renumbering present Section 9 to make it read Section 10."

### APPOINTMENT OF 1954 REFERENCE COMMITTEES

The chairman announced the appointment of reference committees for the 1954 session as follows:

#### 1. Sections and Section Work:

Harold C. Ochsner, Indianapolis (Marion), chairman  
Lester D. Bibler, Indianapolis (Marion)  
William C. McConnell, Sunman (Ripley)  
Elmer C. Singer, Fort Wayne (Allen)  
James F. Peck, Princeton (Gibson)

#### 2. Rules and Orders of Business:

A. P. Hauss, New Albany (Floyd), chairman  
Frank Green, Rushville (Rush)  
Ralph C. Eades, Valparaiso (Porter)  
V. L. Turley, Fowler (Benton)  
Will W. Washburn, Lafayette (Tippecanoe)

#### 3. Medical Education and Hospitals:

G. O. Larson, LaPorte (LaPorte), chairman  
D. D. Dickson, Greensburg (Decatur)  
G. B. Wilder, Anderson (Madison)  
C. G. Kern, Lebanon (Boone)  
Glen V. Ryan, Indianapolis (Marion)

#### 4. Legislation:

Ray Elledge, Hammond (Lake), chairman  
Lawson J. Clark, Indianapolis (Marion)  
F. R. N. Carter, South Bend (St. Joseph)  
John Owen, Indianapolis (Marion)  
Joseph E. Dudding, Hope (Bartholomew-Brown)

#### 5. Public Relations:

W. U. Kennedy, New Castle (Henry), chairman  
William C. Reed, Bloomington (Owen-Monroe)  
J. P. Vye, Gary (Lake)  
Milton H. Omstead, Petersburg (Pike)  
Hubert T. Goodman, Terre Haute (Vigo)

#### 6. Hygiene and Public Health:

J. William Wright, Sr., Indianapolis (Marion), chairman  
Clay A. Ball, Muncie (Delaware-Blackford)  
Truman E. Caylor, Bluffton (Wells)  
V. Earle Wiseman, Greencastle (Putnam)  
W. G. Pippenger, Brook (Jasper-Newton)

#### 7. Amendments to the Constitution and By-Laws:

T. R. Hayes, Muncie (Delaware-Blackford), chairman  
Alfred Ellison, South Bend (St. Joseph)  
Robert H. Rang, Washington (Davies-Martin)  
G. S. Fessler, Rising Sun (Dearborn-Ohio)  
Raymond J. Modjeski, Hammond (Lake)

#### 8. Reports of Officers:

J. R. Doty, Gary (Lake), chairman  
C. S. Black, Warren (Huntington)  
Earl W. Mericle, Indianapolis (Marion)  
Minor Miller, Evansville (Vanderburgh)  
John M. Paris, New Albany (Floyd)

#### 9. Credentials:

W. C. Stover, Boonville (Warrick), chairman  
Glen Ward Lee, Richmond (Wayne-Union)  
D. D. Stiver, South Bend (St. Joseph)  
Sam Rotman, Jasonville (Greene)  
Paul R. Tindall, Shelbyville (Shelby)



**10. Insurance:**

H. R. Stimson, Gary (Lake), chairman  
J. W. Denny, Indianapolis (Marion)  
Elton R. Clarke, Kokomo (Howard)  
M. C. Topping, Terre Haute (Vigo)  
E. L. Fitzsimmons, Evansville (Vanderburgh)

**11. Miscellaneous Business:**

William H. Garner, New Albany (Floyd),  
chairman  
Cleon A. Nafe, Indianapolis (Marion)  
Maurice E. Glock, Fort Wayne (Allen)  
Kenneth L. Olson, South Bend (St. Joseph)  
John Palm, Brazil (Clay)

**ADDRESS OF THE PRESIDENT**

The address of the President, DR. WM. HARRY HOWARD, is printed on page 000 in the December, 1954, JOURNAL of the Indiana State Medical Association. This address was referred to the Reference Committee on Reports of Officers and approved by that committee.

**ADDRESS OF THE PRESIDENT-ELECT**

DR. WALTER L. PORTEUS, president-elect, presented the following address, which was referred to the Reference Committee on Reports of Officers:

Mr. President, members of the House of Delegates:

This is hardly an address. As president-elect, I want you to know that I am afraid it is later than you think. At least, that's as far as I am concerned.

I want to take this opportunity to thank all of you—delegates, officers, councilors and members of the Executive Committee—for your cooperation in my request for suggestions for committees for the coming year. As you know—I hope you received your mail—I wrote to each and every one of you with the idea of trying to make my committees as representative as possible for the next year and I asked you for your suggestions for individuals from your particular area whom you thought would be capable, willing and interested in serving on committees for the Indiana State Medical Association. The appointment of these committees, I would have you know, is quite a gigantic task and I don't believe I could have accomplished this without the superb help of Mr. Jim Waggener.

In the appointment of the committees I had several points in mind; one was to establish a certain continuity of action. Therefore, I tried to leave on these committees certain men who had had some experience in relation to the committees on which they served. I also tried to take into consideration the type of practice so that every type would be represented on my committees. I also tried to take into consideration the geographic distribution of members of the committee as well as your past performance on committees, and frankly, gentlemen, the names of men who did not attend meet-

ings on previous committees were dropped without any question. And there were also constitutional limitations which I had to comply with in order to appoint these committees.

Now, in the very near future I would like to have a meeting of the chairmen of all of the standing and special committees for the purpose of trying to outline a plan of action for the coming year. I would like to suggest to these chairmen that we try to make our organization a leader and not a follower, as we have been sometimes in the past. And I hope with your continued support that we, in an effort to increase the effectiveness of our organization, continue to provide the best medical care possible to the public.

And I implore you to be active in your local areas, both in the civic and political areas, as well as state and national politics. And I would like for you to remember that this coming year is a legislative year and that the best work as far as politics is concerned is done at your own local grass roots level.

**REPORT OF REFERENCE COMMITTEE  
ON REPORTS OF OFFICERS**

DR. J. ROBERT DOTY, chairman, presented the following report which was adopted:

Dr. Porteus' address as incoming president showed evidence of thought and fine character and confirms our confidence that the administration of the office will be in good hands.

**ADDRESS OF PRESIDENT OF  
WOMAN'S AUXILIARY**

MRS. HARRY C. HARVEY, Fort Wayne, president of the Woman's Auxiliary to the Indiana State Medical Association, presented the following report, which was referred to the Reference Committee on Reports of Officers:

Since the fiscal year of the State Auxiliary and that of the Indiana State Medical Association do not coincide, and OUR annual meeting and election of officers is held in April, it is necessary that I incorporate in my report many of the accomplishments of the year of my predecessor, Mrs. W. Burleigh Matthew. Since six months of my year are now ending, I shall mention the goals we have set up for this year in connection with the results of last year.

Our first real accomplishment this year has been the compiling and editing of something entirely new in the way of a "Program Book." Under the capable chairmanship of Mrs. Walter Porteus, and with the help of her committee, we are proud to present this book. Filled with usable, workable suggestions from all our Committee Chairmen, as well as much information gathered from many sources, we believe it to be a blueprint of Auxiliary work, and it should help all Auxiliaries, of whatever size, to work out a well-rounded program of definite Auxiliary work.

We wish to thank the Executive Committee of the I. S. M. A., and Mr. Waggener and his office staff, for their help in producing this book. Also, to Dr.

Portteus, who was sent out for meals, or was not allowed to come home for them, and who suffered much inconvenience by reason of having his home filled with the materials which accompanied the assembling of this book, our special thanks!

Last year we had 89 of our 92 counties organized into 65 active county auxiliaries. We had a total of 2,451 members. We have been informed that the Medical Society has 1,368 more members than the Auxiliary. This would lead one to believe there are many bachelors in Indiana! If this is not the case, we have still quite a field in which to work. It is true that two of our counties, each with perhaps about 20 potential members, are not organized. We hope the Medical Societies of these counties will encourage them to organize within the next year.

On the strength of these figures, we have set a modest goal of 200 new members for this year. We should exceed it.

Our Nurse Recruitment program is most popular, and many Auxiliaries work on this project. Last year 27 counties assisted 46 girls, through loans, gifts and scholarships. Many Auxiliaries gave parties, with appropriate programs, for high school students interested in becoming nurses, and some sponsored "Future Nurses' Clubs" in our high schools. All together, Indiana Auxiliaries spent a total of \$7,386.00 on this program.

This year, we know many more counties are working on Nurse Recruitment, and we hope to surpass even this splendid record.

Pushing the advertisement and sales of TODAY'S HEALTH magazine is peculiarly an Auxiliary project. Even though it is a potent public relations medium for the medical profession, we find that the State Medical Association has no chairman for this project. On the other hand, an elaborate contest system has been set up by the national TODAY'S HEALTH office, for the Auxiliary. First, second, and third place financial awards are given to Auxiliaries in three size classes, for making the highest percentage over their quotas. Then there are three "Clubs" in which Auxiliaries are placed according to their sales percentages. The quota of each Auxiliary is the NUMBER OF ITS MEMBERS.

Last year, Kosciusko County, with Mrs. Lyman Roesch, chairman, made 1,089 per cent and received a \$15.00 award from National for the highest percentage in her size class. Of this we are very proud! Thirteen other counties also received national recognition in varying degrees for going above their quotas. But, no state with more than 2,000 members has ever reached its quota.

Our goal? We want to sell more than 2,450 subscriptions to this magazine, and perhaps be the first to be recognized for this performance at the national meeting in Atlantic City next June!

We need your help for this goal! We know that many of you already subscribe, but you do not want Auxiliary members to disturb you in your busy offices to get subscriptions, and I don't blame you! But, you could invite your county Auxiliary TODAY'S HEALTH Chairman, and her committee, to come to your county medical meeting, to set up a table and take subscriptions as you come in; or, if you send in your own check to pay for your subscription, please write in, "To the credit of the (your) County Auxiliary." Then your subscription will not be lost, as far as the contest is concerned. With 3,819 doctors in Indiana, surely every doctor who has a reception room should have a subscription to TODAY'S HEALTH! Also, make it a point to send TODAY'S HEALTH to a few people as Christ-

mas gifts this year. It only costs \$1.50 a year for the profession, and what gift could be more appropriate from a doctor?

The American Medical Education Foundation is another project which has been given to us by our parent organization. Since this is also a Medical Society project, we have tried to MAKE most of this money ourselves. More than 50 per cent of our Auxiliaries contributed last year, and our gifts totaled more than \$5,148.00. Indiana was recognized at the national meeting in San Francisco for having the largest contribution per member. Also, two of our counties, Marion and Vanderburgh, were cited for having given more than \$1,000 each to this fund.

Dr. James Denny, your Medical Education Foundation chairman, last year suggested that we set a goal of \$10,000. We did not reach it. This year, we would like to reach this goal. Since Mrs. Frank Gastineau, our own popular Auxiliary member, from Indianapolis, is national chairman, we would especially like to make a good showing.

This year, we are suggesting that each member try to make \$5.00, as that much per member would reach our goal. If you wish to help us, why not surprise your wife by handing her a \$5.00 bill and telling her to give it to A. M. E. F. When she recovers consciousness, I'm sure she would be more than grateful!

As auxiliary members, we try to keep informed on legislation pertaining to the medical profession, by means of the Washington letters from the A. M. A. office, and the Secretary's letters from Chicago. We sent letters to all state officers and county presidents, asking them to write their Senators to oppose compulsory inclusion of doctors in the Social Security bill. We try to study candidates for office, and many counties actively engage in helping "Get out the Vote."

Through all these mediums we feel we are actively engaged in public relations work, and are thus aiding our husbands' profession.

## REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS

DR. J. ROBERT DOTY, chairman, presented the following report, which was adopted:

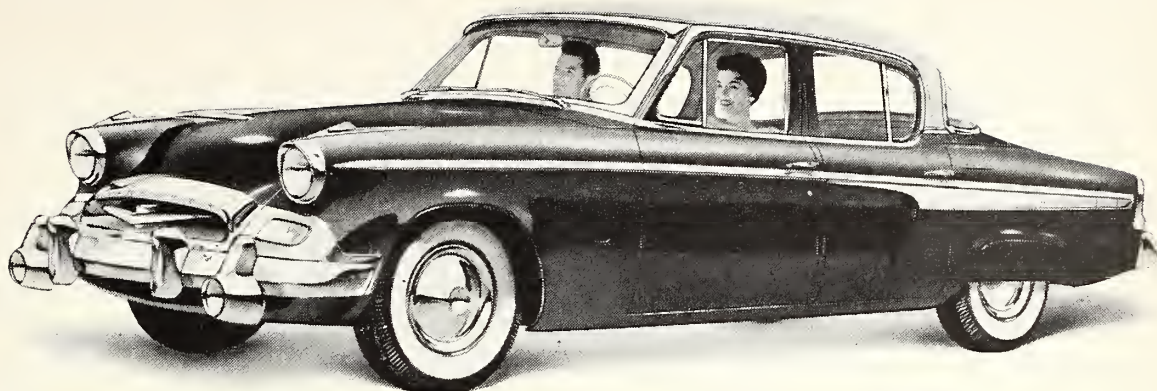
We also want to commend the Woman's Auxiliary on the excellent work they have done during the past year, and especially on the yearbook which they have put out which indicates an enormous amount of work that has been done and shows a good understanding of problems of the medical men of Indiana as seen by the wives of the physicians.

## MATTERS REFERRED TO THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House

(Continued on Page 1436)

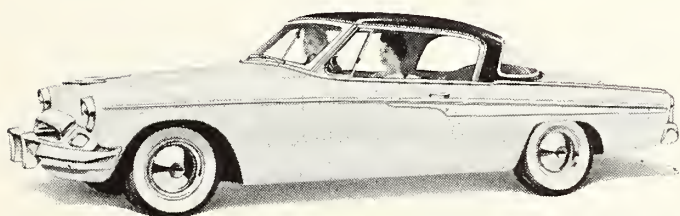




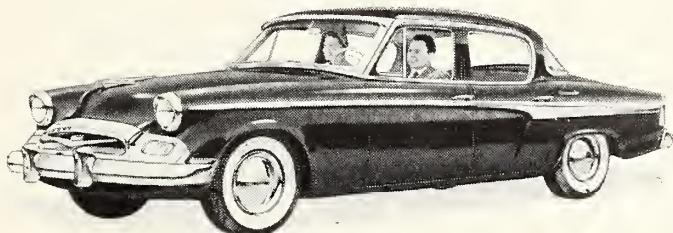
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and referred to this committee are printed herewith.

EXECUTIVE SECRETARY (pages 1138-1140)

TREASURER (pages 1140-1144)

CHAIRMAN OF COUNCIL (pages 1144-1145)

COUNCILOR REPORTS (pages 1146-1160)

EXECUTIVE COMMITTEE (pages 1162-1166)

DR. JAMES W. DENNY, chairman of the Executive Committee, supplemented his written report with the announcement that the Association would have a booth in the exhibit hall during the state convention to demonstrate the recording equipment which Eli Lilly & Company had given the Association, and to show the vast amount of recording that is being done by the Association, Indiana being the largest tape recording state among the state medical societies.

AUDITING COMMITTEE (page 1188)

EDITOR OF THE JOURNAL (page 1204)

#### REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

DR. J. ROBERT DOTY, chairman, presented the following report, which was adopted:

The reports of the executive secretary, the treasurer, the chairman of the Council, the councilors, the Executive and Auditing Committees, the Woman's Auxiliary, and the editor of THE JOURNAL were reviewed by the reference committee and were approved as printed in the Handbook.

We want to call particular attention to the report of Councilor Blazey and suggest that the entire membership read this through as it is very pertinent and to the point.

#### MATTERS REFERRED TO REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

The following reports of standing and special committees were referred to the Reference Committee on Sections and Section Work. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association.

COMMITTEE ON SCIENTIFIC EXHIBITS

COMMITTEE ON SCIENTIFIC WORK

COMMITTEE ON INSTRUCTIONAL COURSES  
(page 1198).

#### REPORT OF REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

DR. HAROLD C. OCHSNER, chairman, presented the following report, which was adopted:  
The Reference Committee on Sections and Section

Work met at 9:00 a.m., October 25, 1954, and submits the following report:

##### a. Report of Committee on Instructional Courses.

The program offered by this committee has been reviewed and we heartily commend the committee for the excellence of the instructional courses, continuing the best traditions of the past.

##### b. Report of the Committee on Scientific Exhibits.

The reference committee is particularly impressed by the increase in the number of exhibits and the excellence of their quality. The location of the exhibits this year is the best we have ever observed and because of their high quality and excellent location they will excite far more than the usual interest.

We would urge that the scientific exhibits be made readily accessible in the future. Your reference committee recommends also (1) that consideration be given to the offering of awards for the best exhibits in the future; (2) that there be published in THE JOURNAL complete information in regard to the scientific exhibits including such data as the size of available space, what is provided in the way of physical equipment, who may exhibit, what type of exhibits are particularly desired, and what is required of the exhibitor in the way of supervision of the booth and physical equipment that he must supply.

c. Report of Committee on Scientific Work. The reference committee congratulates this committee on the excellence of the program, its arrangement and the wise selection of topics of general interest. We hope that the ten-minute papers will be acceptable both to the essayist and the audience but urge that the committee revert to longer papers in the future if the new arrangement is not entirely satisfactory.

#### MATTERS REFERRED TO THE REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS (page 1182).

#### REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. G. O. LARSON, chairman, submitted the following report, which was adopted:

The Reference Committee on Medical Education and Hospitals has considered the report of the

permanent Committee on Medical Education and Hospitals and wishes to commend the committee for its activities and recommends the adoption of the report. We especially commend Dr. Denny for his excellent work on behalf of the Medical Education Foundation.

REPORT OF SUBCOMMITTEE ON PRECEPTORSHIPS (page 1187), and the following supplementary report, presented by Dr. Lester D. Bibler, chairman:

Eight medical students have participated in preceptorship training. Completed reports have been received from four preceptees and four preceptors. All comments are favorable. Eight students withdrew from the program for financial reasons. Dr. E. W. Shrigley, chairman of the preceptorship committee of the Indiana University School of Medicine recommends that this program be continued. It is the recommendation of this committee that this Sub-committee on Preceptorship be continued.

The Sub-committee on Preceptorship of the Indiana State Medical Association wishes to thank the Indiana University School of Medicine for their interest in preceptorship training. It is further recommended that medical students participating in this program be given academic credit in their elective course for time spent in this type of

medical education. And be it further resolved that a copy of this report be forwarded to the Dean of the Indiana University School of Medicine.

The chairman wishes to thank all the members of this committee for their loyalty and cooperation during the past year.

DR. BIBLER also announced that his Preceptorship Committee had a booth at this convention and invited all of the delegates to visit this booth.

#### REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. G. O. LARSON, chairman, presented the following report, which was adopted:

The Reference Committee has considered the report of the Sub-Committee on Preceptorships which appears on page 183 of the Handbook and recommends the adoption of the report with the deletion of the following words in paragraph 3:

"and it is recommended that this House of Delegates recommend to the Council of the Indiana University School of Medicine that credit be given to all students who participate in Preceptorship Training of thirty days or more."

It is recommended that the supplementary report

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of the Preceptorship Committee be adopted with the deletion of the following words in paragraph 2:

"It is further recommended that medical students participating in this program be given academic credit in their elective course for time spent in this type of medical education."

The committee recommends the acceptance of this portion of the report.

#### RESOLUTION ON ESSENTIALS OF AN APPROVED INTERNSHIP

The following resolution was presented by the Fort Wayne (Allen County) Medical Society, and was referred to the Reference Committee on Medical Education and Hospitals:

##### Resolution No. 3

#### RESOLUTION ON THE ESSENTIALS OF AN APPROVED INTERNSHIP

WHEREAS, The House of Delegates of the American Medical Association at the Clinical Session in Denver, Colorado, Dec. 2-5, 1952, adopted the "Report of the Advisory Committee on Internship" together with "Essentials of an Approved Internship" with the belief, that the Council on Medical Education and Hospitals would use its discretion in the application of the new requirements to individual hospitals, and

WHEREAS, This report recommends quote "That no new hospitals should be encouraged to apply for approval in the absence of arrangements for out-

patient experience integrated with inpatient care and that in the foreseeable future all hospitals lacking this should not be continued on the approved list." (Page 506 J.A.M.A., Feb. 7, 1953) and

WHEREAS, It is impracticable, impossible and undesirable for many hospitals to establish new clinics and outpatient departments, and

WHEREAS, The establishment of such departments tends to place more hospital institutions into the private practice of medicine, and

WHEREAS, Such departments in private hospitals are not for the best interest of the patient, as it tends to destroy the individual free choice of doctors by patients and thus alters the doctor-patient relationship, and

WHEREAS, This ruling discriminates against those hospitals who do not already have established outpatient departments and clinics, and thus unfairly practically excludes and makes it impossible for them to obtain interns, and

WHEREAS, Private hospitals and staffs can provide many other satisfactory means for good internship training especially for those interns desiring experience in General Practice.

NOW, THEREFORE, BE IT RESOLVED, That this section of the report be rescinded by the House of Delegates of the A.M.A. and that the House of Delegates of the A.M.A. go on record as opposed to any future policies or actions that tend to encourage hospitals to encroach upon the private practice of medicine:

AND BE IT FURTHER RESOLVED, That the Indiana State Medical Association be and it is further

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hereby requested to call the above subject matter to the immediate attention of the American Medical Association by like resolution.

(This resolution was passed by the unanimous vote of those present at the regular business meeting of the Fort Wayne (Allen County) Medical Society, September 21, 1954).

#### RECOMMENDATION OF COUNCIL ON ESSENTIALS OF AN APPROVED INTERNSHIP

DR. ELTON R. CLARKE, chairman of the Council, reported that the Council had approved this resolution.

#### REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. G. O. LARSON, chairman, submitted the following report, which was adopted:

The reference committee has considered the resolution presented by the Allen County Medical Society which appears on page 111 of the handbook and wishes to present the following amended resolution:

##### RESOLUTION

WHEREAS, the House of Delegates of the American Medical Association at the Clinical Session in Denver, Colorado, December 2-5, 1952, adopted the "Report of the Advisory Committee on Internship" together with "Essentials of an Approved Internship" with the belief that the Council on Medical Education and Hospitals would use its discretion in the application of the new requirements to individual hospitals, and

WHEREAS, this report recommends, quote "That no new hospitals should be encouraged to apply for approval in the absence of arrangements for outpatient experience integrated with inpatient care and that in the foreseeable future all hospitals lacking this should not be continued on the approved list." (Page 506, J. A. M. A., February 7, 1953) and

WHEREAS, confusion has arisen as to what constitutes an outpatient department and thus qualifies a hospital for acceptance on the approved list for interns, and

WHEREAS, present rulings of the A. M. A. Advisory Committee on Internships would seem to discriminate against those hospitals which do not have established outpatient departments as defined by this committee and thus unfairly make it impossible to obtain interns, and

WHEREAS, the entire State of Indiana has only two hospital units providing full outpatient care, and

WHEREAS, intern training in most general hospitals includes emergency department service, outpatient x-ray and outpatient laboratory service, and

other allied services which are rendered by large hospital outpatient departments, and

WHEREAS, the full scale outpatient department is practical only in the medical centers where a large number of indigent cases are available, and

WHEREAS, the establishment of such full scale outpatient departments would tend to place more hospital institutions in the private practice of medicine, and

WHEREAS, such departments in private hospitals are not for the best interests of the patient, as they tend to destroy the individual free choice of doctors by patients, and thus alter the doctor-patient relationship,

NOW, THEREFORE, BE IT RESOLVED, that this section of the report be rescinded by the House of Delegates of the A. M. A. and that the House of Delegates of the A. M. A. go on record as opposed to any future policies or actions that tend to encourage hospitals to encroach upon the private practice of medicine:

AND BE IT FURTHER RESOLVED, that the Indiana State Medical Association be hereby requested to call the above subject matter to the immediate attention of the American Medical Association by like resolution.

The committee recommends the acceptance of this portion of the report.

#### RESOLUTION ON JOINT COMMISSION ON ACCREDITATION

DR. H. R. STIMSON presented the following resolution which had been adopted on October 20, 1954, by the Lake County Medical Society, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, this House of Delegates at its 1953 session endorsed and commended the Joint Commission on Accreditation of Hospitals for its work, and made several suggestions to it designed to help it in its work, and

WHEREAS, many hospitals have since been surveyed by the Commission, or are anticipating surveys in the future, and

WHEREAS, examples are beginning to appear where certain of such hospitals are using these surveys as justification for many changes in their medical staff regulations, and are presenting new constitutions and by-laws to their staffs, and

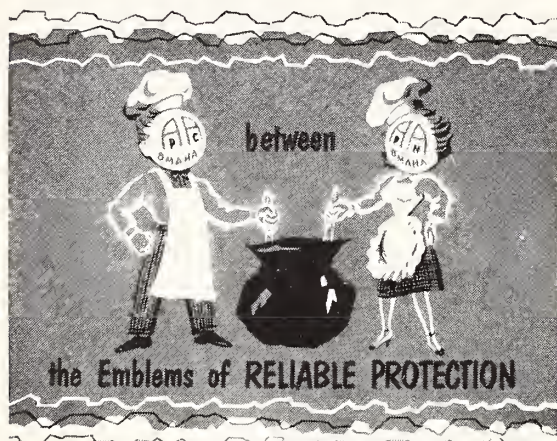
WHEREAS, it was the recommendation of this House in 1953 that such changes ought properly to be initiated by the staff itself, and

WHEREAS, many of these hospital-initiated changes have been arbitrary, beyond the requirements set up by the Commission, and even on occasion unfairly discriminatory, placing wholly un-

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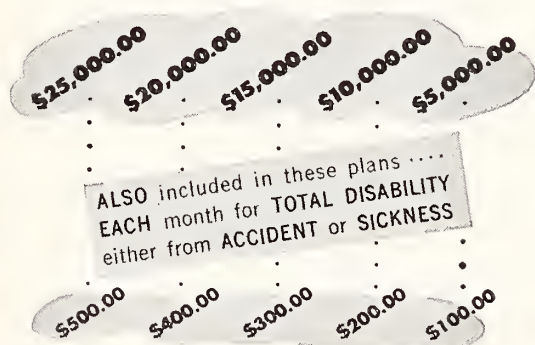
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necessary restrictions on the medical staff, for example, on all men engaging in one type of practice, and

WHEREAS, it is the belief of this House that such was never the purpose or the intention of the Commission, the five agencies who created it, or the Indiana State Medical Association,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association protest such action, both directly and with the assistance of the proper officers of the American Medical Association, to the Commission whenever such abuses occur or have already occurred, and urge upon the Commission the imperative need for clear direction from it to all hospitals that the Commission is opposed to unnecessary and punitive measures taken against members of the medical staffs, and will score them adversely for such action.

### REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. G. O. LARSON, chairman, presented the following report, which was adopted:

The committee has considered the Lake County Medical Society resolution and desires to present the following amended resolution:

WHEREAS, this House of Delegates at its 1953 session endorsed and commended the Joint Commission on Accreditation of Hospitals for its work, and made several suggestions to it designed to help it in its work, and

WHEREAS, many hospitals have since been surveyed by the Commission, or are anticipating surveys in the future, and

WHEREAS, examples are beginning to appear where certain of such hospitals are using these surveys as justification for many changes in their medical staff regulations, and are presenting new constitutions and by-laws to their staffs, and

WHEREAS, it was the recommendation of this House in 1953 that such changes ought properly to be initiated by the staff itself, and

WHEREAS, many of these hospital-initiated changes have been arbitrary, beyond the requirements set up by the Commission, and even on occasion unfairly discriminatory, placing wholly unnecessary restrictions on the medical staff, and

WHEREAS, it is the belief of this House that such was never the purpose or the intention of the Commission, or of the five agencies who created it, or of the Indiana State Medical Association,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association protest such action, both directly and with the assistance of the proper officers of the American Medical Association to the Commission whenever such abuses occur or have already occurred, and urge upon the Commission the imperative need for clear direction from it to all hospitals that the Commission is opposed to unnecessary and punitive measures taken against members of the medical staffs, and will score them adversely for such action, and

BE IT FURTHER RESOLVED, that the permanent Committee on Medical Education and Hospitals of the I. S. M. A. distribute copies of this resolution to the secretaries of each hospital staff in the State of Indiana, together with the recommendation that



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"It is strange," Malleison says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.<sup>1</sup>

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1. Malleison, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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each hospital staff become familiar with the regulations promulgated by the Joint Commission on Accreditation, and

BE IT FURTHER RESOLVED, that hospital inspections by the Joint Accreditation Commission be made only with the full knowledge of the medical staff and the hospital board, and that such inspection be conducted with a representative of each department of the staff, and at the conclusion of the inspection the findings be presented to the entire staff.

We recommend the acceptance of this portion of the report.

#### MATTERS REFERRED TO THE REFERENCE COMMITTEE ON LEGISLATION

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the October, 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

#### REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION (page 1182)

#### REPORT OF COMMITTEE ON ALCOHOLICS STUDY (pages 1187-1188)

#### REPORT OF REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, presented the following report, which was adopted:

The Reference Committee on Legislation, consisting of Drs. Lawson J. Clark, F. R. N. Carter, John Owen, Joseph E. Dudding and Ray Elledge, chairman, submits the following report on matters referred to it:

(1) It commends the Committee on Public Policy and Legislation for the services that committee has rendered the Association and approves its report as submitted on page 175 of the Handbook.

Mr. President, I move the adoption of this part of my committee's report.

(2) Our committee has studied the report of the Committee on Alcoholics Study, printed on page 183 of the Handbook. Your special attention is invited to the first sentence in the second paragraph on page 184 in which the committee recommends that at least two members of the Alcoholics Beverage Commission be physicians. Our committee approves the report and commends the work of the Alcoholics Study Committee.

Mr. President, I move the adoption of this part of my committee's report.

#### RESOLUTION ON QUALIFICATION OF CORONERS

The following resolution, introduced by the Porter County Medical Society, was referred to the Reference Committee on Legislation:

##### Resolution No. 6

RESOLVED, That the Indiana State Medical Association sponsor a bill to make mandatory that the office of Coroner be occupied only by a qualified Doctor of Medicine, except in counties having five or less doctors, who will thus be able to act as a Medical Examiner.

(The above resolution was authorized by unanimous vote of the Porter County Medical Society.)

#### RECOMMENDATION OF COUNCIL ON RESOLUTION ON QUALIFICATION OF CORONERS

DR. ELTON R. CLARKE, chairman of the Council, announced that the Council had referred this resolution to the House of Delegates without recommendation.

#### REPORT OF THE REFERENCE COMMITTEE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, presented the following report, which was adopted:

(3) Our committee has had under consideration resolution No. 6 which has to do with the qualifica-

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tions of coroners. That resolution was printed on page 113 of the Handbook. After careful study by our committee and upon the legal advice to the effect that the office of coroner is a constitutional office and cannot be changed by an act of the Legislature, our committee felt constrained to recommend that this proposed resolution be rejected. Our committee concluded that the only thing that could be done would have to be done through county medical societies encouraging physicians to seek the office.

Mr. President, I move that this part of our report be approved and adopted.

#### RESOLUTION ON AMENDMENT TO MEDICAL PRACTICE ACT

The following resolution, introduced by the Porter County Medical Society, was referred to the Reference Committee on Legislation:

##### Resolution No. 5

RESOLVED, That the Indiana State Medical Association sponsor a bill to amend the Indiana State Medical Practices Act to require that all persons practicing the Medical Arts in the State of Indiana be required to complete a one-year internship prior to being granted a license.

(The above resolution was authorized by unanimous vote of the Porter County Medical Society.)

#### RECOMMENDATION OF COUNCIL ON RESOLUTION ON AMENDMENT TO MEDICAL PRACTICE ACT

DR. ELTON R. CLARKE, chairman of the Council, reported that the Council had referred this resolution to the House of Delegates without recommendation.

#### REPORT OF THE REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, presented the following report, which was adopted:

(4) Our committee had under consideration resolution No. 5 printed in the Handbook on page 113 under which a requirement of one year of internship would be made necessary for one to obtain a license to practice any form of the healing arts. The committee approved the resolution upon condition that it could be handled by the Legislative Committee without opening the Medical Practice Acts as they now exist.

Mr. President, I move that this part of our report be approved and adopted.

#### RESOLUTION ON COUNTY GENERAL HOSPITAL GOVERNING BOARDS

The following resolution from the Porter County Medical Society was referred to the Reference Committee on Legislation:

##### Resolution No. 7

#### COUNTY GENERAL HOSPITAL GOVERNING BOARDS

WHEREAS, A County General Hospital is a tax-supported and charitable institution and

WHEREAS, Doctors of medicine are usually considerable payers of all forms of taxes, and

WHEREAS, The medical profession, as a whole, is a part of the community which supports the hospital the doctors use to accomplish treatment of their patients, and

WHEREAS, The Doctors are the ones who, alone, are capable of directing the many treatments rendered within the confines of a County General Hospital, and

WHEREAS, It is the ultimate good of the patient—the important one in all good medical practice, and

WHEREAS, There is a definite strengthening of the lay-thinking of any Board of Trustees through the advice of a licensed Doctor of Medicine, and

WHEREAS, Patients treated in County General Hospitals have all the other advantages of Doctors working in a harmoniously well-organized, departmentalized, self-governing Medical Staff, and

WHEREAS, Doctors are permitted only to attend meetings which are held openly but cannot sit in on closed meetings to represent their profession and their patients, and

WHEREAS, Doctors are best able to choose their own representatives,

BE IT THEREFORE RESOLVED, That the Indi-



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ana State Medical Association sponsor a bill before the next session of the Indiana General Assembly in 1955, that would make the Chief of the Medical Staff, duly elected by said staff members, annually, a regular and legal member of said County General Hospital's Board of Trustees or Governors.

(The above resolution was authorized by unanimous vote of the Porter County Medical Society.)

The following amendment to Resolution No. 7, introduced by the Whitley County Medical Society, was referred to the Reference Committee on Legislation:

The Whitley County Medical Society in their regular session on October 12, 1954, voted to amend Resolution No. 7 as follows:

That in place of "Chief of Medical Staff," it be amended to read "President of Medical Staff," and that such person be unable to head the County General Hospital's Board of Trustees or Governors.

#### RECOMMENDATION OF COUNCIL ON RESOLUTION ON COUNTY GENERAL HOSPITAL GOVERNING BOARDS

DR. ELTON R. CLARKE, chairman of the Council, reported that the Council had referred this resolution to the House of Delegates without recommendation.

#### REPORT OF THE REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, presented the following report which was adopted:

(5) We have had under consideration resolution No. 7 concerning inclusion of physicians on county general hospital governing boards, printed on page 113 of the Handbook. In considering that resolution we also considered the motion to amend, which was submitted by the Whitley County Medical Society. After consideration of the resolution and the motion to amend, the committee approved the resolution with the motion to amend in principle and found favorably on the question of the substance and sentiment of the resolution but because of the large variety of ways in which county and other public hospitals have been organized in Indiana, no clear way seemed open to accomplish the purpose of the resolution. We therefore recommend that the legal staff of the Indiana State Medical Association draw up a bill consistent with the resolution and motion, if it is found feasible by the Legislative Committee and the legal staff and that the presentation of such bill to the Legislature be left to the discretion of the Legislative Committee of the Indiana State Medical Association.

Mr. President, I move the approval and adoption of this part of our report.

#### RESOLUTION REQUESTING CHANGE IN P. L. 761

The following resolution, introduced by Dr. A. G. Blazey, Washington, was referred to the Reference Committee on Legislation:

Resolution No. 8

#### RESOLUTION REQUESTING CHANGE IN P. L. 761

WHEREAS, Section 106 of P. L. 761 is a formidable means to bring about socialized medicine under cover of the federal employment of physicians to certify as to total disability for waiver of so-called premiums under the Social Security set-up, and,

WHEREAS, This same section can be augmented to include waiver of tax for temporary disabilities, and eventual cash benefits, requiring additional physicians to implement the expansion, and,

WHEREAS, The AMA has proposed a means of accomplishing a reasonable solution to this problem by using the five or ten best years of a worker's earnings in computing retirement benefits, without recourse to any physical examination with its additional expense and socializing dangers, and

WHEREAS, The threat of this opening wedge for socialized medicine is not appreciated by our legislators, now,

THEREFORE, BE IT RESOLVED, That the I. S. M. A. goes on record, at its annual meeting in Indianapolis, this 27th day of October, 1954, as being opposed to this dangerous section, and as requesting its removal by the 84th Congress, and

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to all members of Congress for the purpose of having them remove this encroachment on the private practice of medicine.

A. G. Blazey, M.D.  
Councillor, 2nd District  
10-5-54

#### REPORT OF REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, presented the following report which was adopted:

(6) Your committee considered resolution No. 8 requesting a change in P. L. 761, printed on page 114 of the Handbook. This resolution is in regard to Federal employment of physicians to certify to total disability under the existing Social Security law. The committee recommends the approval of the resolution. Mr. President, I move that this part of our committee's report be approved and adopted.

#### RESOLUTION ON FEES IN INSANITY INQUESTS

DR. H. R. STIMSON, Gary, introduced the following resolution, which was referred to the Reference Committee on Legislation:

WHEREAS, The present law of the State of Indiana permits the payment of a three dollar fee for



the service of a physician at an insanity inquest, and

WHEREAS, This fee was established back in times when the value of the dollar was five or six times its present day value, and

WHEREAS, This condition imposes an unwarranted hardship on physicians willing to perform these duties, and makes many of them reluctant to do so,

NOW, THEREFORE, BE IT RESOLVED, That the Indiana State Medical Association use its utmost influence at the 1955 Session of the General Assembly of the State of Indiana to amend this law to permit a fee of at least ten dollars for a physician's service at insanity inquests.

Proposed and adopted by the Council of the Lake County Medical Society at its regular meeting October 3, 1954 for submission to the House of Delegates of the Indiana State Medical Association on October 24, 1954.

#### REPORT OF REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, presented the following report which was adopted:

(7) Our committee had under consideration the resolution presented by the Lake County Medical Society to the effect that the organization sponsor in the 1955 Legislature an amendment to the law regarding physicians' fees in insanity inquests to permit the amount of the fee to be at least \$10.00. The committee approves the resolution.

Mr. President, I move that this part of our report be approved and adopted.

#### RESOLUTION TO MAKE CITIZENSHIP MANDATORY TO PRACTICE THE MEDICAL ARTS IN INDIANA

DR. GORDON B. WILDER, Anderson, introduced the following resolution which was referred to the Reference Committee on Legislation:

WHEREAS, The Indiana State Board of Medical Registration and Examinations, since World War II, has been literally flooded by applications for license to practice the medical arts within this state by foreign medical school graduates, who have made no effort to obtain United States citizenship.

WHEREAS, Many other states have deemed it necessary to require United States citizenship before granting a license to practice the medical arts within the confines of their state.

WHEREAS, Such action would greatly simplify and aid the endless work of the Indiana State Board of Medical Registration and Examinations.

THEREFORE BE IT RESOLVED, That the Indiana State Medical Association sponsor a bill in the next session of the Indiana State Legislature to make it mandatory that an applicant for license to practice the healing arts in any form or manner in the State of Indiana, must be a citizen of the United States or a citizen of a territorial possession of the United States of America.



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## REPORT OF REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, submitted the following report, which was adopted:

(8) Our committee has had under consideration the resolution presented by the Madison County Medical Society pertaining to the requirement that no license be granted to any person to practice any of the medical arts within the State of Indiana unless he is a citizen of the United States or of a territorial possession of the United States.

The committee approves the resolution as presented, subject to whatever legal limitations exist and provided that it can be presented to the Legislature in such a manner as not to open the Medical Practice laws now existing.

Mr. President, I move that this part of our report be approved and adopted.

## PROPOSED BILL TO CREATE AN INDIANA BOARD OF OPHTHALMIC DISPENSERS

A bill which would create a board of Ophthalmic Dispensers was brought to the attention of the House of Delegates and was referred by the chairman to the Reference Committee on Legislation.

## RECOMMENDATION OF COUNCIL ON OPHTHALMIC BILL

DR. ELTON R. CLARKE, chairman of the Council, reported that the Council had voted to refer this bill to the House of Delegates without recommendation.

## REPORT OF REFERENCE COMMITTEE ON LEGISLATION

DR. RAY ELLEDGE, chairman, submitted the following report, which was adopted:

(9) Our committee has had under consideration the proposed bill to create an Indiana Board of Ophthalmic Dispensers. We recommend that the bill be approved in principle and that the Indiana State Medical Association support it in the next session of the Legislature, with whatever changes and amendments are found appropriate by the Legislative Committee of the Association.

Mr. President, I move that this part of our report be approved and adopted.

Mr. President, I move that the report of the Reference Committee on Legislation be accepted and adopted as a whole.

## MATTERS REFERRED TO THE REFERENCE COMMITTEE ON PUBLIC RELATIONS

The following reports of standing and special committees were referred to the Reference Committee on Public Relations. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association.

## BOARD OF APPEALS ON PHYSICIAN-PA- TIENT RELATIONS (pages 1166-1168)

## COMMITTEE ON PUBLIC RELATIONS (page 1183)

## COMMITTEE ON PUBLICITY (page 1184)

## COMMITTEE ON RURAL HEALTH (pages 1184-1186)

## COMMITTEE ON ANTI-NATIONAL HEALTH INSURANCE (page 1188)

## COMMITTEE ON NECROLOGY (page 1201)

## COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION (no published report)

DR. G. O. LARSON announced that he had just been assigned the chairmanship of this committee, due to ill health of the chairman appointed for the year, and that he had the following report to make:

The Committee on School Health and Physical Education wishes to report that on Wednesday, October 20, the Fourth Annual Statewide Conference on Schools and Physical Education was held in the Student Union Building on the Indiana University Medical School Campus here in Indianapolis. The meeting was widely attended, and, according to the reports that have been received, it was the best conference that has been sponsored by this committee.

## COMMITTEE ON STATE FAIR (page 1201)

## LIAISON COMMITTEE WITH LABOR (page 1204)

## REPORT OF REFERENCE COMMITTEE ON PUBLIC RELATIONS

DR. W. U. KENNEDY, chairman, presented the following report, which was adopted:

1. In regard to the Board of Appeals on Patient-Physician Relations, the Reference Committee recognizes the importance of this work and its inherent difficulties requiring much diplomacy. The committee approves and recommends the adoption of the report.

2. In regard to the Committee on Public Relations, the Reference Committee commends the News Flashes and the booklet on Public Relations and recommends that the work of this committee be continued. We recommend adoption of their report.

3. The Committee on Publicity is commended for its activities, and the Reference Committee recommends that the present activities be continued and that their report be adopted.

4. The Reference Committee notes with satisfaction the work of the Committee on Rural Health and recommends the adoption of their report and continuance of their activity.

5. The Committee on Anti-National Health Insurance had no report. The Reference Committee recognizes the importance of the purpose of this committee but recommends that its duties be merged into the Committee on Legislation.

6. The Reference Committee recommends the



adoption of the report of the Committee on Necrology.

7. The Committee on School Health and Physical Education did not submit a report.

8. The Committee on State Fair submitted a report of its activities. We recommend the adoption of the report with special commendation for the cooperation of the Woman's Auxiliary.

9. The Liaison Committee with Labor had no activities, but the Reference Committee feels it has a field of usefulness and should be continued.

#### MATTERS REFERRED TO THE REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

#### COMMITTEE ON INDUSTRIAL HEALTH (page 1169)

a. REPORT OF SUBCOMMITTEE ON SILICOSIS (page 1169)

b. REPORT OF SUBCOMMITTEE ON NOISE IN INDUSTRY (pages 1170-1180)

COMMITTEE ON CANCER (page 1190)

COMMITTEE ON CHRONIC ILLNESS (pages 1190-1192)

COMMITTEE ON CIVIL DEFENSE (page 1193), and the following supplementary report, presented by Dr. Glen Ward Lee, chairman:

Mr. Chairman, members of the House of Delegates:

The plans and purpose of the Internal Security Corps were secured by the Committee from Col. Charles Hutchings, Jr., its Deputy Director. This information was sought because newspaper articles have ambiguously reported that the Internal Security Corps would take over certain functions of Civil Defense. Information given by Colonel Hutchings indicates that the Internal Security Corps, currently being organized, will be used as a supplement to the existing and future organization of Civil Defense and will not replace any segment thereof. Its primary functions are to provide an additional state-controlled Auxiliary Police Corps; also, a Transportation Section under the control of the state and the enlisted men of the organization will be trained in first aid.

The Internal Security Corps would serve as a nucleus for a State Guard organization in the event that the Thirty-eighth National Guard Division was called out of the state into federal service. The entire number of doctors authorized for inclusion in the present organization of the Internal Security Corps numbers 21, including those assigned to the headquarters of the organization and

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to the battalions of the organization where they would serve as medical officers for the enlisted personnel.

It is suggested that the present Civil Defense Committee composed of five members be reconstituted in future committees as follows: One representative from each Councilor District in the state, a part of whose duties it would be to check on the Medical Civil Defense organization of each county within his Councilor District, to stimulate and assist Civil Defense committees of county medical societies to select a county health services director who will be active and who possesses qualities of leadership. The district representatives should also see to it that county Civil Defense committees assist their county health services director in the assignment of each physician in their county to a Civil Defense responsibility.

The state committee should also include a representative of each Section of the State Medical Association, so that he may act as a liaison officer between the Civil Defense organization and his particular section of organized medicine. The purpose here would be to secure advice and assistance from his particular section as it may be needed by the state Civil Defense organization, in planning for and organizing certain special units required to meet specific needs.

Medical Civil Defense needs the wholehearted cooperation of organized medicine. By expanding the personnel of the committee and giving its members certain specific responsibilities, it is hoped that Medical Civil Defense will be given added impetus and wider participation toward the goal where every physician will have a specific assignment in a Civil Defense emergency.

COMMITTEE ON CONSERVATION OF VISION (pages 1193-1194)

COMMITTEE ON CRIPPLED CHILDREN SERVICES (page 1194)

COMMITTEE ON DIABETES (page 1195)

COMMITTEE ON HARD OF HEARING (pages 1195-1197)

COMMITTEE ON HEART DISEASE (page 1197)

COMMITTEE ON MATERNAL AND CHILD HEALTH (pages 1198-1199)

COMMITTEE ON MENTAL HEALTH (not published in JOURNAL. Printed on pages 207 and 208 of the Delegates' Handbook)

COMMITTEE ON TRAFFIC SAFETY (page 1201)

COMMITTEE ON TUBERCULOSIS (pages 1201-1202)

COMMITTEE ON VENEREAL DISEASE (pages 1202 and 1203)

## REPORT OF REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

DR. J. WILLIAM WRIGHT, chairman, presented the following report, which was adopted section

by section and as a whole, on motions made by Dr. Wright, duly seconded with amendments as indicated:

Your Reference Committee on Hygiene and Public Health has reviewed the reports of the various committees presented to it for consideration and desires to offer the following recommendations to the House of Delegates:

1. Report of Committee on Industrial Health, page 156, Handbook.

a. Report of Subcommittee on Silicosis

The reference committee commends the committee for its excellent investigations and recommends that the committee be continued.

b. Report of Subcommittee on Noise in Industry.

The reference committee commends the subcommittee for the study of noise in industry and strongly urges a continuance of this committee and recommends a close relationship with the Committee on Hard of Hearing.

c. Guiding Principles of Occupational Medicine. (Dr. Wright here explained that this is a pamphlet which had been circulated and had been published last spring in THE JOURNAL. A copy of it was handed to the reference committee. It was not printed in the Handbook.)

Your committee urges the adoption of the principles as set forth in the report of the committee on Industrial Health.

2. Report of Committee on Cancer.

Your reference committee feels that in view of the fact that personal opinions appear to have been injected into the report, data from a wider and broader scope should be investigated before any change in the presently accepted methods of approach toward cancer research have been discarded.

3. Report of Committee on Chronic Illness.

Your reference committee suggests that a study be made toward the revamping of county tax-supported homes to the end that those patients who are financially able might be admitted on a pay basis.

4. Report of Committee on Civil Defense.

Your reference committee desires to compliment the Committee on Civil Defense for its excellent service and also extends heartiest compliments on the fine exhibit.

Your committee urges adoption of the supplemental report, as per attached copy.

5. Report of Committee on Conservation of Vision.

Your reference committee desires to compliment the Committee on Conservation of Vision and approves its objectives insofar as they will not be at variance with the Medical Practice Act.

6. Report of Committee on Crippled Children Services.

Your reference committee wishes to commend the Committee on Crippled Children Services and approves of its objectives in principle. Further study and investigation are recommended.

7. Report of Committee on Diabetes.

Your reference committee wishes to commend the Committee on Diabetes and encourage it to continue the fine work it is doing.

8. Report of Committee on Hard of Hearing.

The reference committee recommends that all problems on hearing difficulties be referred to the Committee on Hard of Hearing and a close relationship be maintained with the Subcommittee on Noise in Industry.

9. Report of Committee on Heart Disease.

Your reference committee recommends that activities of the Committee on Heart Disease be under the jurisdiction of physicians.

10. Report of Committee on Maternal and Child Health.

Your reference committee commends the Committee on Maternal and Child Health for its excellent work and suggests a continuance of that project.

11. Report of Committee on Mental Health.

Your reference committee wishes to commend the Governor for his endeavors in the field of the mentally ill and recommends that the President of this Association appoint a committee of three to visit the Governor and urge the procurement of more and competent personnel rather than the expenditure of funds for additional housing units.

(DR. F. R. N. CARTER moved that this section of the report "be amended by deleting the part dealing with building." Motion seconded by Dr. R. P. Good. Discussed by Drs. Mericle, E. S. Jones, Denny, Lee, Good and Eades. Motion adopted.)

Dr. Wright moved that this portion of the report be adopted as amended. Motion seconded and carried. The report of the Reference Committee, therefore, reads as follows:

Your reference committee wishes to commend the Governor for his endeavors in the field of the mentally ill and recommends that the President of this Association appoint a committee of three to visit the Governor and urge the procurement of more and competent personnel.

12. Report of Committee on Traffic Safety.

Your reference committee strongly urges activity on the part of the Traffic Safety Committee and a close relationship with the State Police Department.

13. Report of Committee on Tuberculosis.

Your reference committee heartily concurs with the recommendations of the Committee on Tuberculosis.

Your committee also suggests that the Committee on Tuberculosis investigate the policy of some hospitals of refusing re-admittance to patients with an active lesion who voluntarily left the institution.

14. Report of Committee on Venereal Disease.

Your reference committee commends the Committee on Venereal Disease and urges physicians to report their cases to the State Board of Health.

**BILL CONCERNING EDUCATION AND TRAINING OF CHILDREN HANDICAPPED BY HEARING DEFICIENCY**

A bill which would provide for the education and training of children who are handicapped by a hearing deficiency was brought to the attention of the House of Delegates and was referred to the

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#### RECOMMENDATION OF THE COUNCIL ON "HEARING-HANDICAPPED CHILDREN BILL"

DR. ELTON R. CLARKE, chairman, reported that the Council had voted to refer this bill to the House of Delegates without recommendation.

#### REPORT OF THE REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

DR. J. WILLIAM WRIGHT, chairman, submitted the following report which was adopted:

Your reference committee recommends that this House of Delegates approve a bill to be introduced to the next State Legislature for the education and training of children who are handicapped by a hearing deficiency.

#### RESOLUTION FROM ST. JOSEPH COUNTY MEDICAL SOCIETY

DR. F. R. N. CARTER introduced the following resolution, which was referred to the Reference Committee on Hygiene and Public Health:

A RESOLUTION against an exorbitant and unnecessary waste of the taxpayers' money and

Against the socialization of a private enterprise, which if carried out among other business activities will aid in expanding federal bureaucracy and ultimately end in political tyranny.

WHEREAS: The United States of America has become a dominant power among nations as a result of the great system of private enterprise enjoyed equally by all of its citizens, and

WHEREAS: The socialization of any enterprise will destroy the initiative that has given the courage and energy to any citizen or any group of citizens to risk the hazards of new undertakings or the pursuit of scientific investigation, and

WHEREAS: The United States of America has engaged in six wars in the last sixty years, and

WHEREAS: At the present time there are 20,200,000 ex-service men, which constitutes 40 per cent of the wage-earning male population of the United States, and

WHEREAS: The great majority of these ex-service men had no service connected disability whatsoever but were honorably discharged in as good health as when they entered the service, and

WHEREAS: Within a period of ten years, at the present rate of draft, enlistment and retirement, 50 per cent of all the able-bodied American men will have served in armed forces of the United States, and

WHEREAS: Under existing laws and the current policies of the United States Veterans Administration, more than 20,200,000 ex-service men (40 per cent of the wage-earning male population of the United States) are now potentially eligible for free hospitalization and medical and surgical care for ANY illness or injury, even though such ailments have no

connection whatsoever with service in the Armed Forces, and

WHEREAS: Any veteran can now obtain free hospitalization and medical and surgical care for non-service connected injuries or illness by simply affirming that, in his opinion, he cannot afford to pay for such care, and under present laws and regulations no investigation can be made to determine the truth of that statement or his ability to pay, and

WHEREAS: Within about ten years, at present rates of draft, enlistment and retirement, one-half of all able-bodied American men will have served in the Armed Forces and will be able to claim free hospital, medical and surgical care by simply deciding and stating that they cannot afford to pay for it, and

WHEREAS: Veterans Administration hospitals are now occupied by approximately 100,000 bed patients each day, two-thirds of whom are being treated for ailments which have no connection with their service in the Armed Forces, while only about 35,000 war injured veterans (this includes Korea) occupy beds in the 169 Veterans Administration hospitals in any given day, and all of these patients could be given the finest possible care in 50 or 60 hospitals, and

WHEREAS: Chronic illness such as tuberculosis and the various types of mental disease may develop long after discharge from the armed forces, provisions should be made for the care of such cases, by the Veterans Administration until they can be adequately cared for in the local community, and

WHEREAS: More and more ex-servicemen will suffer from the illnesses of old age as time goes by and it is not difficult to imagine that more and more middle income veterans will be prompted to declare that in their opinion they cannot afford the extraordinary costs of illness and to thereby claim the free hospitalization and medical and surgical care provided by the Veterans Administration, and

WHEREAS: Already at the local level of government, ways and means of rendering hospital, medical and surgical treatment are available to all indigent ex-servicemen suffering with non-service connected disabilities, in the same way as they are rendered to all other indigent citizens, and

WHEREAS: The cost to the American taxpayers for the present hospital system (169 Veterans Administration hospitals), of the Veterans Administration is nearly \$700,000,000 per year, to care for about 100,000 bed patients each day, and one of the foremost authorities on veterans affairs has conservatively estimated that, if present policies are continued, the Veterans Administration will have to add 200,000 more hospital beds and more than double the number of Veterans Administration hospitals, and

WHEREAS: Already 6,300 doctors, 859 dentists and 13,800 trained nurses are required to operate the 169 hospitals, out-patient departments, etc., and

WHEREAS: This number of doctors, dentists and nurses will be more than doubled if 200 more hospitals, each with 1,000 bed capacity, are built, and

WHEREAS: Doctors, dentists and nurses are subject to draft at any time by the Federal Government and may be called to active duty in the Army or Navy if it becomes necessary to staff additional hospitals, and

WHEREAS: This would not only lower the standard of hospital, medical and surgical care in the local community, but would be a threat to the ex-



istence of our present type of hospital, medical and surgical care,

NOW, THEREFORE, BE IT RESOLVED BY THE ST. JOSEPH COUNTY MEDICAL SOCIETY: That the Society firmly supports the policy of furnishing to each and every veteran the finest possible hospital, medical and surgical care for all service connected disabilities and to every veteran who was discharged with service connected disability, and further that it favors the construction of all hospital facilities necessary for that purpose, but emphatically opposes the furnishing of free hospital, medical or surgical care for non-service connected disabilities incurred by veterans who were discharged in good physical condition at the end of their period of governmental service. The Society further urges that such services be discontinued and that no additional hospital beds be constructed for the free care of veterans with non-service connected ailments,

BE IT FURTHER RESOLVED: That the pursuit of the present Veterans Administration policy is an unfair, unnecessary and wasteful use of the American taxpayers' dollar and,

BE IT FURTHER RESOLVED: That the pursuit of the present policy of the Veterans Administration, if continued, will result in the socialization of the practice of medicine, which is an undesirable governmental movement, which, if pursued in other types of private enterprise will result in the socialistic state.

BE IT FURTHER RESOLVED: That this resolution be presented to the Indiana State Medical Association at its annual meeting which will be held in Indianapolis on October 23 to October 26, 1954, inclusive, and

BE IT FURTHER RESOLVED: That it be released to the press and other interested groups for their consideration.

SO BE IT RESOLVED.

#### REPORT OF THE REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

DR. J. WILLIAM WRIGHT, chairman, presented the following report:

##### 15. Resolution from St. Joseph County.

Your reference committee realizes that there have been and are abuses in connection with admissions to veterans hospitals and it strongly urges a close relationship between the American Legion, the Veterans of Foreign Wars, and the Indiana State Medical Association.

##### Action on Section 15 of Report of Reference Committee on Hygiene and Public Health

DR. WRIGHT moved, and Dr. Shields seconded, that this portion of the report be adopted.

DR. NAFE: "Mr. President, I move that this be amended so that this House of Delegates will also go on record as endorsing the position that has been taken by the American Medical Association House of Delegates relative to the care of veterans." Seconded by Dr. Blazey.

Discussed by Drs. Nafe, Wright of Fort Wayne, Blazey, Bibler, Norman Booher (on special vote of House on point of privilege), Shields, Hess, and Hammond.

On standing vote, Dr. Nafe's motion was passed, 55 to 43.

The House then voted to accept this portion of the report, as amended by Dr. Nafe, on motion of Dr. Wright, duly seconded.

On motion of Dr. Wright, duly seconded, the House adopted the report of the Reference Committee on Hygiene and Public Health as a whole with amendments.

DR. WRIGHT: "I wish to thank the men who discussed the various reports before the committee.

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I also wish to thank the members of this committee for their valuable suggestions and prompt response to call."

#### **MATTERS REFERRED TO REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BYLAWS**

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

#### **REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS (pages 1168-1169)**

#### **REPORT ON REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS**

DR. T. R. HAYES, chairman, presented the following report, which was adopted:

This reference committee reviewed the report of the standing Committee on Constitution and Bylaws which contained the resolution regarding the appointment of staggered committees. The committee approves the adoption of this resolution, and we so move.

#### **AMENDMENT TO BYLAWS PROVIDING FOR APPOINTMENT OF PSYCHIATRIST TO MEMBERSHIP OF BOARD OF APPEALS**

The following amendment, approved by the Council, was referred to the Reference Committee on Amendments to the Constitution and Bylaws:

BE IT RESOLVED, That Section 13, Chapter VIII, be amended by adding thereto the following paragraph:

In addition to the above provided membership and organization of the Board, the president of the Association shall appoint an accredited psychiatrist as a specialty member of the Board whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any Councilor District of the Association irrespective of the membership of the Board including another member from the same Councilor District. He shall have the same rights and privileges as other members of the Board and be subject to the rules, regulations and methods of procedure as approved by the Council of the Association.

#### **REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION**

DR. T. R. HAYES, chairman, presented the following report, which was adopted:

The reference committee also considered the proposed amendment to the Bylaws providing for the addition of a psychiatrist to the membership of the

Board of Appeals, and we move that this amendment be adopted.

#### **RESOLUTION ON CREATION OF OFFICES OF FIRST AND SECOND VICE-PRESIDENTS**

DR. JAMES W. DENNY, under suspension of the rules, presented the following resolution, which was referred to the Reference Committee on Amendments to the Constitution and Bylaws on motion of Drs. Nafe and Mericle:

WHEREAS, There are yearly some members of our association who for physical reasons, financial reasons, or other causes too numerous to mention, which would prevent these members from ever being honored with the presidency of our association, and

WHEREAS, These said members, in many cases, have in their lifetime given much time and effort in working to forward the ideals of our association;

THEREFORE, BE IT RESOLVED, That the office of first and second vice-president be created in our association to honor such members; and

BE IT FURTHER RESOLVED, That these offices are of an honorary nature and shall not succeed to the office of presidency in case of death of the incumbent president.

#### **REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS**

DR. T. R. HAYES, chairman, presented the following report which was adopted:

The committee met in emergency session and discussed this resolution.

Inasmuch as the committee feels that this association has functioned fairly satisfactorily in the past and due to the limitation of time to give adequate consideration to the resolution, it is the committee's opinion that this resolution should be referred to the standing committee for their study and recommendation to the next House of Delegates.

Mr. Chairman, we move that the report of this reference committee be adopted as a whole.

#### **MATTERS REFERRED TO REFERENCE COMMITTEE ON INSURANCE**

The following matters were referred to the Reference Committee on Insurance. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

#### **COMMITTEE ON MEDICAL CARE INSURANCE (page 1200)**

#### **REPORT OF REFERENCE COMMITTEE ON INSURANCE**

DR. H. R. STIMSON, chairman, presented the following report, which was adopted:



Your committee has studied and discussed the report of the Standing Committee on Medical Care Insurance appearing on pages 205-206 in the Handbook and recommends its adoption with the following amendments:

That the word "membership" be inserted after "district" in paragraph numbered "1." That at the end of the same paragraph the following be added: "and shall be sent to the State Association's Council for approval and recommendation to the Blue Shield Board."

That in paragraph numbered "3," the following be added after the word "Association," "and a member of the District Society." That the words "a district" be deleted and the words "the district membership" be substituted therefor. That following the word "Board" at the end of the paragraph, the following be added, "not to exceed two consecutive terms."

#### RESOLUTION ON HEALTH INSURANCE AND RELATED MATTERS FROM THIRD DISTRICT MEDICAL SOCIETY

The following resolution, introduced by the Third District Medical Society, was referred to the Reference Committee on Insurance:

##### Resolution No. 2

WHEREAS, Health insurance has enjoyed acceptance by the public and the medical profession as among the desirable methods of helping defray the costs of health care; and

WHEREAS, The members of the American Medical Association, State and County Medical Societies are bound by the Principles and Code of Ethics of the American Medical Association; and

WHEREAS, The Indiana State Medical and American Medical Associations have repeatedly affirmed that anesthesiology, pathology and radiology constitute the practice of medicine; and

WHEREAS, Certain insurance companies issue and certain corporations accept medical care policies which provide payment for electrocardiogram, x-ray examinations and x-ray therapy, and laboratory

examinations for non-hospitalized out-patients payable only to the hospitals; this payable in some cases only to the hospital if the hospital issues the bill or the work is done by a salaried employed physician; and

WHEREAS, Such provisions encourage and further the practice of medicine by hospitals and do not allow the patient a free choice of physicians resulting in unfair competition and discrimination against those physicians doing special examinations outside of hospitals; and

WHEREAS, These provisions tend to encourage the practice of employment of physicians by hospitals, and result in a form of fee splitting between the physicians and hospitals; therefore be it

RESOLVED, That all health insurance companies and corporations should in formulating their health insurance plans adhere strictly to the basic principles of the medical profession as enunciated by the American Medical Association; and be it further

RESOLVED, That any medical service which is to be the basis of a benefit payment shall be stated as a medical service and shall not be referred to in such terms as "hospital service," "auxiliary service," etc., nor shall such medical service be qualified by such phrases as "when rendered by a salaried employee of a hospital" or "when rendered by an employee of a hospital," or any wording which would convey a similar meaning; and be it further

RESOLVED, That whereas corporations and insurance companies are operating under the capitalistic system of free enterprise as does the medical profession; therefore, corporations and insurance companies should not be a party to insurance contracts that tend to undermine the medical profession by encouraging any group whether hospitals, corporations, insurance companies or government to control the medical profession and thereby lower the standard of health care to our people; and be it further

RESOLVED, That the Lawrence County Medical Society go on record as opposed to any insurance plan that will tend to encourage exploitation or discrimination against any member or group of members of the medical profession; and that this matter be brought to the attention of the Indiana State Medical Association and that the necessary corporations and insurance companies operating in this state be so notified through the Indiana State Chamber of Commerce.

(The above resolution was adopted unanimously by the Third District Medical Society at Jasper, Indiana, on May 26, 1954.)

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### RECOMMENDATION OF COUNCIL ON THIRD DISTRICT RESOLUTION ON HEALTH INSURANCE, ETC.

DR. ELTON R. CLARKE, chairman of the Council, reported that the Council has approved this resolution.

### REPORT OF REFERENCE COMMITTEE ON INSURANCE

DR. H. R. STIMSON, chairman, presented the following report, which was adopted:

Your committee has also held discussions on Resolution No. 2 submitted by the Third District Medical Society, on pages 109-110 of the Handbook, and recommends its adoption with the following changes:

That wherever the words "health insurance" appear, they be changed to read "medical insurance."

That the fifth WHEREAS be changed, deleting the words "and do not allow the patient a free choice of physicians," and the words "And limits the patient's free choice of physician" be placed at the end of the paragraph.

That in the sixth WHEREAS the words "and result in a form of fee splitting between the physicians and hospitals" be deleted.

That the third RESOLVED paragraph be divided and altered as follows: The words, "WHEREAS corporations and insurance companies are operating under the capitalistic system of free enterprise as does the medical profession" be made the last of the "WHEREAS" paragraphs, and the balance of the paragraph become the first of the "RESOLVED that" paragraphs.

That the last of the "RESOLVED" paragraphs be changed as follows: The words "Indiana State Medical Association" be substituted for "Lawrence County Medical Society." The sentence "and that this matter be brought to the attention of the Indiana State Medical Association and that the necessary corporations and insurance companies operating in this state be so notified through the Indiana State Chamber of Commerce" be deleted, and the following substituted therefor: "a copy of this resolution be sent to the Indiana State Chamber of Commerce and to the corporations and insurance companies operating in this state."

The resolution, as revised by the reference committee, reads as follows:

WHEREAS, Medical Insurance has enjoyed acceptance by the public and the medical profession as among the desirable methods of helping defray the costs of health care; and

WHEREAS, The members of the American Medical Association, State and County Medical Societies are bound by the Principles and Code of Ethics of the American Medical Association; and

WHEREAS, The Indiana State Medical and American Medical Associations have repeatedly affirmed

that anesthesiology, pathology and radiology constitute the practice of medicine; and

WHEREAS, Certain insurance companies issue and certain corporations accept medical care policies which provide payment for electrocardiogram, x-ray examinations and x-ray therapy, and laboratory examinations for non-hospitalized out-patients payable only to the hospitals; this payable in some cases only to the hospital if the hospital issues the bill or the work is done by a salaried employed physician; and

WHEREAS, Such provisions encourage and further the practice of medicine by hospitals and limit the patient's free choice of physician, resulting in unfair competition and discrimination against those physicians doing special examinations outside of hospitals; and

WHEREAS, These provisions tend to encourage the practice of employment of physicians by hospitals; and

WHEREAS, Corporations and insurance companies are operating under the capitalistic system of free enterprise as does the medical profession; therefore be it

RESOLVED, That corporations and insurance companies should not be a party to insurance contracts that tend to undermine the medical profession by encouraging any group whether hospitals, corporations, insurance companies or government to control the medical profession and thereby lower the standard of medical care to our people; and be it further

RESOLVED, That all medical insurance companies and corporations should, in formulating their medical insurance plans, adhere strictly to the basic principles of the medical profession as enunciated by the American Medical Association; and be it further

RESOLVED, That any medical service which is to be the basis of a benefit payment shall be stated as a medical service and shall not be referred to in such terms as "hospital service," "auxiliary service," etc., nor shall such medical service be qualified by such phrases as "when rendered by a salaried employee of a hospital" or "when rendered by an employee of a hospital," or any wording which would convey a similar meaning; and be it further

RESOLVED, That the Indiana State Medical Association go on record as opposed to any insurance plan that will tend to encourage exploitation or discrimination against any member or group of members of the medical profession, and a copy of this resolution be sent to the Indiana State Chamber of Commerce and the corporations and insurance companies operating in this state.

### MATTERS REFERRED TO REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the October 1954, Vol. 47, No. 10, JOURNAL of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

COMMITTEE ON CONVENTION ARRANGEMENTY OFFICERS' CONFERENCE (page 1168)

COMMITTEE ON CONVENTION ARRANGEMENTS—no written report

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL—no written report

COMMITTEE ON MILITARY MANPOWER (page 1200)

COMMITTEE ON VETERANS AFFAIRS (page 1204)

LIAISON COMMITTEE WITH INDIANA ASSOCIATION OF LICENSED NURSING HOMES (page 1204)

#### REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. WILLIAM H. GARNER, chairman, presented the following report, which was adopted:

1. *Report of Committee on Conference of County Medical Society Officers.* The reference committee commends the Committee on Conference of County Medical Society Officers for sponsoring an interesting and informative program on March 7, 1954. We recommend the adoption of this report.

2. *The Committee on Convention Arrangements* is to be commended on the excellent program of entertainment they have provided for this convention. On behalf of the House of Delegates and the members of the Association, your reference committee wishes to thank the Convention Arrangements Committee for its efforts in making this a most successful convention. We move the adoption of this report.

3. *Committee on Indiana Inter-Professional Health Council.* This committee did not submit a report. Your reference committee feels that this is an activity that should receive more attention and active participation from our members on the committee, and that a full report should be rendered in the future.

4. *The report of the Committee on Military Manpower* was accepted with commendation by the reference committee, and we move the adoption of this report.

5. *Report of Committee on Veterans Affairs.* Your reference committee defers action on the personal opinion of the chairman of the Veterans Affairs Committee in lieu of a resolution that is before another reference committee. The committee approved the portion of the report pertaining to the fee schedule. We move the adoption of this section of the report.

6. *Report of Liaison Committee with Indiana Association of Licensed Nursing Homes.* The committee approved this report and we recommend its adoption.

#### RESOLUTION ON SPONSORING A MEDICAL ESSAY CONTEST

The following resolution, introduced by the Madison County Medical Society, was referred to the Reference Committee on Miscellaneous Business:

##### Resolution No. 4

#### RESOLUTION FOR THE INDIANA STATE MEDICAL ASSOCIATION TO SPONSOR A MEDICAL ESSAY CONTEST

WHEREAS, The issues of private practice versus socialized medicine and human freedom versus socialism require a spirited fight for the impressionable young minds of the nation's youth, and

WHEREAS, The Purdue University Opinion Poll reveals that approximately 55 per cent of the nation's high school students approve of socialized medicine, and

WHEREAS, There is a continuing need for educational programs to enlighten the new group of high school students each year, and

WHEREAS, Essay contests have proven to be a most effective medium, in 27 other states, to educate our youth away from socialism.

THEREFORE, BE IT RESOLVED, That the Indiana State Medical Association sponsor a statewide essay contest, offering suitable cash prizes, the title of which shall be "The Advantages of Private Medical Care" and that all Indiana County Medical So-



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cieties be urged to sponsor the contest at their respective county levels.

(The above resolution is sponsored by the Madison County Medical Society.)

#### RECOMMENDATION OF COUNCIL ON RESOLUTION SPONSORING A MEDICAL ESSAY CONTEST

DR. ELTON R. CLARKE, chairman, reported that the Council has approved this resolution.

#### REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. WILLIAM H. GARNER, chairman, presented the following report, which was adopted:

*7. Resolution No. 4, regarding sponsoring a medical essay contest.* The committee recommends that this resolution be referred to the standing Committee on Public Relations as to the feasibility and methods of implementation.

#### APPRECIATION OF THE PRESIDENT

DR. WILLIAM H. GARNER, chairman of the Reference Committee on Miscellaneous Business, read the following supplement to his committee's report, which was adopted unanimously:

Your reference committee wishes to express the unanimous feeling of appreciation of this House of Delegates for a most successful year under the leadership of our President, Dr. Wm. Harry Howard. His untiring efforts and hard work during the past year deserve the sincere thanks of this House of Delegates.

#### ELECTION OF OFFICERS

The following officers were elected:  
President-elect:

Dr. Walter U. Kennedy, New Castle  
Treasurer:

Dr. Roy V. Myers, Indianapolis  
Assistant Treasurer:

Dr. Richard P. Good, Kokomo

AMA delegates, for term expiring December 31, 1956:

Dr. Cleon A. Nafe, Indianapolis

Dr. E. S. Jones, Hammond

AMA alternate delegates, elected for term expiring December 31, 1956:

Dr. Earl W. Mericle, Indianapolis

Dr. William C. Wright, Fort Wayne

#### ADDRESS OF PRESIDENT-ELECT WALTER U. KENNEDY

The newly elected President-elect Dr. Walter U. Kennedy, was escorted to the platform, and addressed the House as follows:

Mr. President, and Gentlemen: As a little boy I learned English, some German, and as I went to school I had some other languages, but in all of them I have not found any words that can express adequately the real emotional feeling that I have. I thank you from the bottom of my heart. I pledge to you a continuation of what has been my life work, the practice of medicine and the good of the profession. Whatever I may be able to do I want your support, and I pledge to you the full support, Doctor Portteus, and when it is my time to come in, I ask for that same support for myself. We are interested in the good of the profession, not our own personal good, and that is one of the reasons why medicine and doctors have the standing they do with the public. I hope it may continue and I hope we may all work together to make medicine even more powerful and more valuable to the people. I thank you very much.

DR. E. H. CLAUSER appeared before the House and expressed his appreciation for the consideration given him for the office of president-elect and suggested that a motion be made that the election of Dr. Kennedy be declared unanimous. Motion made by Dr. Black, duly seconded, and carried.

#### PLACE OF 1956 ANNUAL CONVENTION

DR. LESTER D. BIBLER read a letter from Dr. Russell J. Spivey, president of the Indianapolis Medical Society, and one from Alex M. Clark, mayor of Indianapolis, inviting the association to meet in Indianapolis again in 1956. On motion of Drs. Elton R. Clarke and Ralph Eades, the House voted to accept these invitations to hold the 1956 convention in Indianapolis.

#### RESOLUTION ON PHYSICIAN- HOSPITAL RELATIONSHIPS

DR. CLAY A. BALL presented the following resolution and moved that it be adopted by the House, acting as a committee of the whole. Motion seconded by Dr. George Daniels, and resolution adopted.

WHEREAS, The subject of physician-hospital relationships has been considered by the House of Delegates of the American Medical Association for the past twenty years, and

WHEREAS, These considerations resulted in the adoption by the House of Delegates of the American Medical Association of the "Guides for Conduct of Physicians in Relationships with Institutions" in December, 1951, and

WHEREAS, Further study of physician-hospital relationships by a joint committee of the Board of



Trustees of the American Medical Association and the American Hospital Association resulted in the adoption by the House of Delegates of the American Medical Association in June, 1953, of the report of this joint committee entitled, "Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and the American Hospital Association," and

WHEREAS, The House of Delegates of the American Medical Association emphasizes that this joint report be supplemental to and does not repeal the guides of 1951, and

WHEREAS, There is no conflict in the guides of 1951 and the report of the joint committee of 1953, and

WHEREAS, This action of the House of Delegates of the American Medical Association December, 1953, was necessary to the proper understanding of the policy of the American Medical Association on physician-hospital relationships,

THEREFORE, BE IT RESOLVED, That the principles of physician-hospital relationships as outlined in the guides of 1951 be reaffirmed by the House of Delegates of the American Medical Association, and

BE IT FURTHER RESOLVED, That these guides of 1951 serve as the basis for the consideration of the physician-hospital relationships by the joint committee of the Boards of Trustees of the American Medical Association and the American Hospital Association, and

BE IT FINALLY RESOLVED, That the delegates to the American Medical Association from the Indiana State Medical Association be instructed to introduce this resolution in the House of Delegates of the American Medical Association at the interim session of 1954.

## RESOLUTIONS OF APPRECIATION

DR. J. ROBERT DOTY presented the following resolution which was adopted unanimously:

WHEREAS, The various committees of the Indianapolis Medical Society have cooperated in diligent fashion to assure the success of this 105th annual convention of the Indiana State Medical Association; and

WHEREAS, Dr. Robert M. Hansell, chairman of the general arrangements committee, and his various sub-committees have staged an excellent program of scientific and entertainment features; now

THEREFORE, BE IT RESOLVED, That this House of Delegates go on record as extending its official thanks to the Indianapolis Medical Society for its fine role as host to the 1954 meeting.

DR. BERNARD D. ROSENAK presented the following resolution in appreciation of the information media, which was adopted unanimously:

WHEREAS, Representatives of the press, radio and television have been generous in their coverage of the 105th annual convention of the Indiana State Medical Association; and

WHEREAS, This nation's information media must be maintained on a free unbiased basis; and

WHEREAS, The vast majority of Indiana's newspapers have supported the efforts of the medical

profession in its campaign against the socialism of medicine; now

THEREFORE, BE IT RESOLVED, That this session of the House of Delegates go on official record as thanking the press, radio and television for their excellent coverage of this, the 105th annual convention of the Indiana State Medical Association.

The House adjourned, sine die, at 12 m.

## MINUTES OF THE GENERAL PRACTICE SECTION MEETING 1954

The Section on General Practice met at 2:00 P. M., Wednesday, October 27, 1954 in the Egyptian Room of the Murat Temple, Indianapolis, Indiana, with Dr. Norman R. Booher, Chairman, presiding.

Minutes of the 1953 meeting were read and approved.

Dr. George L. Thorpe of Wichita, Kansas spoke on "Modern Office Therapeutics," an excellent paper well received by the group of about 125 listeners present. Dr. John DeTar of Milan, Michigan, addressed the Section on "Problems in General Practice." His material was timely and was interestingly received.

Dr. L. D. Bibler presented the following resolution, which was passed by the Section:

### RESOLUTION

WHEREAS, The problems of providing sufficient numbers of general physicians is paramount in rendering comprehensive medical care to the American people, and

WHEREAS, There is evidence that (a) medical students demonstrate less interest in the general practice of medicine as they progress through medical school and internship, (b) problems of hospital staff membership and privileges are intimately related to the dearth of general practice medical personnel, therefore be it

RESOLVED, That this Section of General Practice of the ISMA inform the Indiana delegates to the American Medical Association of a resolution calling upon the A. M. A. to initiate an exhaustive study of the whole problem of the general practice of medicine including (a) its scope and its limitations, (b) the adequacy of preparation for general practice including medical school training, internship and residency training, and its effect on the supply of general physicians, (c) the problems of physicians in relation to the limitation of their hospital staff privileges or their exclusion from hospitals, and the effect of these practices on the quality of medical care, (d) all other problems related to the general practice of medicine as they affect the quality, cost and adequacy of the medical care of the American people.

BE IT FURTHER RESOLVED, That a copy of this resolution be forwarded to the Executive Committee of the Indiana State Medical Association with a request to call it to the attention of the Indiana Delegates to the American Medical Association.

BE IT FURTHER RESOLVED, That this resolution be presented to the House of Delegates of the I. S. M. A. at their next regular session in 1955.

The following officers were elected to serve the Section for the coming year:

Frank H. Green, Jr., Chairman  
Russell J. Spivey, Vice-Chairman  
Keith Hammond, Secretary





# Convention Exhibits—1954

Scientific and technical exhibits were most outstanding in history of ISMA conventions. Three views of interested throngs at booths are shown. Center left, is attractive colonial entrance and lovely professional model-hostess. Model railroad, below, visited by hundreds of hobbyists. Headquarters tape recording setup, right, demonstrated daily by Mrs. Janet Lee.





## District Meeting Reports

### Second Councilor District

The Second District Medical Association held its annual meeting in the Elks Country Club in Sullivan, September 9, with the scientific program beginning at 2 o'clock.

Speakers were Dr. James H. Gosman, Indianapolis, who discussed "Psycho-Cutaneous Eruptions"; Dr. Bill L. Martz, Lilly Clinic, Indianapolis, whose subject was "Mechanisms and Therapy of Congestive Heart Failure"; and Dr. Glenn W. Irwin, Jr., also of Indianapolis, who presented a paper on "Some of the Newer Drugs and Their Uses".

At the business session Dr. J. H. Crowder, Sullivan, was elected councilor for the district; Dr. Herbert O. Chattin, Vincennes, was elected president for 1954-1955; and Dr. J. S. Brown, Carlisle, was reelected secretary. Knox county will entertain the district association in 1955. The date has not been set.

Dinner was served at 6 o'clock, to 65 members and guests, including the Auxiliary. Mrs. Harry C. Harvey, Fort Wayne, Auxiliary president, was introduced.

Dr. Wm. Harry Howard, Hammond, president of ISMA, spoke after the dinner on various activities of the state association. Following Dr. Howard's talk, Dr. I. H. Scott, Sullivan, showed films made during his trip to South America last spring.

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### Seventh Councilor District

The largest district meeting in the history of the Indiana State Medical Association is now claimed by the Seventh District Medical Society as a result of the session held in Indianapolis, September 25, when 516 physicians, their wives and guests registered.

A cocktail party and dinner-dance in the Indianapolis Athletic club was enjoyed. The J. B. Roerig Company acted as host.

At the business session Dr. Joseph F. Ferrara, Franklin, was named president-elect and will succeed Dr. Maurice G. Murphy, Morgantown, at the district's 1955 fall session in Morgan county October 12.

Dr. T. V. Petranoff, Indianapolis, was reelected secretary-treasurer, and Dr. Charles Jones, Franklin, was chosen alternate councilor.

It was voted to hold the Spring meeting May 10 in conjunction with a regular session of the Indianapolis Medical Society.

Dr. Elmer Koch, Danville, outgoing president, presided at the business meeting.

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### Eleventh Councilor District

The Ninety-fourth semi-annual session of the Eleventh Councilor District Medical meeting was held at 1:30 p.m., September 15, in the Mississinewa Country Club, Peru.

Following the introduction and welcome, Dr. C. O. McCormick, Indianapolis, presented a paper on "Obstetrical Problems", and Dr. Richard Halfast, Kokomo, spoke on "Fractures of the Forearm and Elbow".

The councilor's report and election of officers were on the agenda for the business meeting at 4 p.m. Dr. Fred Malott, Converse, was named district president, and Dr. Owen Johnson, Peru, secretary-treasurer. Dr. Elton R. Clarke, Kokomo, was reelected district councilor. The next meeting of the organization will be held May 18, 1955 in Kokomo.

Auxiliary members, who had held their program during the afternoon, joined the doctors for an informal mixer and dinner. After dinner speaker was Walter Bixler, Peru attorney, whose subject was "Change". Kenneth Bush, field secretary, spoke of ISMA headquarters services at the afternoon session, and also spoke briefly at the dinner meeting.

Dr. George W. Wagoner, Delphi, outgoing district president, presided at the meeting.

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# HOME LAWN MINERAL SPRINGS

M. C. PITKIN, M.D., *Medical Director*

J. W. GIBBS, M.D., *Associate*

# News from the County Societies

Eighty-one members of the **Fort Wayne (Allen) County Medical Society** attended the first of the current season's local programs November 2 when members of the St. Joseph's Hospital program committee presented a scientific program on "Anesthesia". Dr. Louis A. Schneider was chairman.

Three papers were presented by members of the hospital staff. They were "Thirty Years in Anesthesia" by Dr. William R. Clark; "The Safest Anesthetic" by Dr. Emory D. Hamilton; and "Regional Anesthetic" by Dr. Russell E. Havens.

Each year the Fort Wayne Society plans one scientific program from each of the three Fort Wayne hospitals. The Parkview staff will present "Radiology" on January 4 and Lutheran staff members will discuss "Pediatrics" on March 1.

The November meeting was held in the Chamber of Commerce where dinner was served at

6:30. A business meeting of the society was also held on November 16.

The GP "Road Show" will be presented in Fort Wayne December 7.

The **Crawford-Harrison County Medical Society** met October 7 in the Harrison County hospital, Corydon, for a dinner meeting. Seven physicians attended.

A joint staff and society business meeting was held. A new member of the society and staff was introduced. He was Dr. Stanley Seipel, a Harrison county native, who is now practicing in Lanesville.

A tape recording on "Use and Abuse of Antibiotics" by Dr. Harold Morris, Louisville, was played by R. J. Amick, field secretary. Mr. Amick also spoke informally of the services



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available to individual doctors and county societies from the state headquarters.

Dr. Robert J. Marvel, Indianapolis, discussed "Recent Advances in the Treatment of Hypertension" at the October 21 meeting of the **Henry County Medical Society**.

Seventeen members attended the 8:45 p.m. meeting in the Henry County hospital, New Castle.

"Common Skin Diseases and Their Treatment" was the topic of a paper presented to members of the **Montgomery County Medical Society** by Dr. John R. Brayton, Indianapolis dermatologist.

The meeting was held October 11 in the Culver Union Hospital, Crawfordsville. Twenty-six members were present for the evening meeting.

Legislation of interest to the group was discussed at a brief business meeting.

The **Orange County Medical Society** held a dinner meeting October 5 in the French Lick Springs Hotel with 11 present.

A brief, routine business meeting preceded the program which was provided by Robert J. Amick, field secretary, who played a recently recorded lecture on "The Use and Abuse of Antibiotics" by Dr. Harold Morris, Louisville. Mr. Amick also spoke concerning the program for the annual ISMA convention.

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Fifteen members of the **Putnam County Medical Society** met October 8 in the Student Union building on the DePauw campus at Greencastle for a dinner meeting.

After the dinner they decided to continue with their present arrangement providing blood supplies to the hospital and discussed other organization business.

Guest speaker for the evening was Dr. William M. Browning, Indianapolis, who discussed "Prematures".

Also on the program for a brief talk was Robert J. Amick, ISMA field secretary.

"Cardiac Surgery" was the general subject of two papers presented by Drs. Mason Jones and Donald Effler of the Cleveland Clinic before the **Tipppecanoe County Medical Society** meeting October 12. Dr. Jones developed the subject from the viewpoint of a cardiologist and Dr. Effler spoke from the viewpoint of a cardiac surgeon. A question and answer period followed.

A business meeting followed the scientific program. Members were urged to participate in Diabetes Week; a resolution was passed thank-

ing Eli Lilly and Company for the program which was arranged for the society; doctors were informed of plans for taking the third blood sample on the polio vaccine trials and hospital staff rules were discussed.

The meeting in Lincoln Lodge, Lafayette, was attended by 48 members and 7 guests.

Twelve members of **Wabash County Medical Society** heard Dr. Howard A. Stellner, Fort Wayne psychiatrist, speak on "Diagnosis and Treatment of Depressed States" at the September 8 meeting in the Sheller hotel, North Manchester.

Dr. Louis Salmon was presented his credentials for membership in the society. He is practicing in Wabash.

The October 13 meeting of the society was also held in the Sheller Hotel, North Manchester, with 14 members attending the dinner.

Guest speaker was Dr. George Manning, Fort Wayne, who presented a paper on "Management of Coma". Dr. Manning is a neurosurgeon.

Dr. Louis Salmon, Wabash, was welcomed as a new member.

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W. N. WRIGHT, M.D. Resident Psychiatrist  
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# *Membership Roster*

## INDIANA STATE MEDICAL ASSOCIATION

Following is a list of members of the Indiana State Medical Association as of December 31, 1953, plus those who have become members between December 31, 1953 and June 1, 1954.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

### ALPHABETICAL LIST OF MEMBERS

#### A

Name	City	County	Name	City	County
Aagesen, J. W.	Anderson	Madison	Allen, Robert T.	Richmond	Wayne-Union
Abel, J. A.	South Bend	St. Joseph	Almquist, C. O.	Gary	Lake
Abel, Robert	Wakarusa	Elkhart	Almquist, Reuben E.	Gary	Lake
Abell, Charles F.	Marion	Grant	Alred, Allen W.	Indianapolis	Marion
Abreu, Benedict E.	Indianapolis	Marion	Altier, W. H.	Fowler	Benton
Acher, Robert P.	Greensburg	Decatur	Alvey, Charles R.	Muncie	Delaware- Blackford
Acker, Robert B.	South Bend	St. Joseph			
Acos, James C.	East Chicago	Lake	Alvis, Edmond O.	Indianapolis	Marion
Acre, R. R.	Evansville	Vanderburgh	Alward, John Haney	Kokomo	Howard
Adair, Fred L. (H)	Maitland, Fla.	Porter	Amberg, Edward A.	Hammond	Lake
Adair, Samuel L.	Jeffersonville	Clark	Ambrose, J. C.	Noblesville	Hamilton
Adair, Wm. K.	Crothersville	Jackson	Amick, Charles L.	Wakarusa	Elkhart
Adams, Charles J.	Kokomo	Howard	Amini, Sohrab	Huntingburg	Dubois
Adams, Max R.	Flora	Carroll	Amos, R. L.	New Castle	Henry
Adams, William B.	Muncie	Delaware- Blackford	Amstutz, Henry C.	Goshen	Elkhart
			Amy, W. E.	Corydon	Harrison- Crawford
Adamski, Michael S.	Logansport	Cass			
Ade, C. H.	Lafayette	Tippecanoe	Anderson, John B.	Vincennes	Knox
Ade, Mary	Lafayette	Tippecanoe	Anderson, John T.	Indianapolis	Marion
Adkins, H. C.	Indianapolis	Marion	Anderson, Milton H.	Evansville	Vanderburgh
Adkins, Onan C.	Indianapolis	Marion	Anderson, R. M.	Vincennes	Knox
Adler, David L.	Columbus	Bartholomew- Brown	Anderson, Walter C.	Terre Haute	Vigo
			Anderson, Wendell C.	Indianapolis	Marion
Adler, Edmund R.	Dyer	Lake	Annis, Homer B.	Bluffton	Wells
Adler, Raymond N.	Evansville	Vanderburgh	Antes, Earl H.	Evansville	Vanderburgh
Adney, Frank B., Jr.	Richmond	Wayne-Union	Appel, Richard H.	Indianapolis	Marion
Aiken, Arthur F.	Ft. Wayne	Allen	Apple, Eddie R.	Salem	Washington
Aiken, Milo M.	Plainfield	Hendricks	Applegate, Albert E.	Frankfort	Clinton
Aiken, N. E.	Ft. Wayne	Allen	Apter, Julia T.	Whiting	Lake
Ake, Loren	Richmond	Wayne-Union	Arata, Justin E.	Fort Wayne	Allen
Albertson, F. P.	Indianapolis	Marion	Arbeiter, Herbert I.	Hammond	Lake
Alcorn, Merritt O.	Madison	Jefferson- Switzerland	Arbogast, J. L.	Indianapolis	Marion
			Arbogast, Paul B.	Vincennes	Knox
Alderfer, Henry	Marion	Grant	Arbuckle, Russell L.	Indianapolis	Marion
Aldrich, Harry	Indianapolis	Marion	Arbuckle, Wm. E.	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion	Arisman, R. K.	South Bend	St. Joseph
Alexander, Ezra D.	Indianapolis	Marion	Arlook, Theodore D.	Elkhart	Elkhart
Alexander, J. E.	Evansville	Vanderburgh	Armavillage, Leon T.	Gary	Lake
Alexander, O. O.	Terre Haute	Vigo	Armington, C. L.	Anderson	Madison
Alexander, P. M.	Martinsville	Morgan	Armington, John C. (S)	Anderson	Madison
Alexander, Stephen J.	Crawfordsville	Montgomery	Armington, Robert	Anderson	Madison
Alford, James	Hamilton	Steuben	Armstrong, T. D.	Michigan City	La Porte
Allegretti, Michael	Hammond	Lake	Arnett, A. C.	Lafayette	Tippecanoe
Allen, Fred K.	New Albany	Floyd	Arney, Amos	Michigan City	La Porte
Allen, Hubert E.	Richmond	Wayne-Union	Arnold, Aaron L.	Indianapolis	Marion
Allen, J. L. (S)	Greenfield	Hancock	Arnold, M. F.	East Chicago	Lake
Allen, L. Howard	Bedford	Lawrence	Arnold, Robert D.	Indianapolis	Marion
Allen, Orris T. (S)	Terre Haute	Vigo	Aronson, Sidney S.	Indianapolis	Marion
Allen, Robert K.	Indianapolis	Marion	Arrowsmith, James L.	Hammond	Lake

Name	City	County	Name	City	County
Arthur, Nora M. (S)	Washington	Daviess-Martin	Barnhart, Willard T.	Evansville	Vanderburgh
Artz, Richard W.	Angola	Steuben	Barnum, Emerson	Shelbyville	Shelby
Asbury, W. D. (S)	Terre Haute	Vigo	Barone, Carmelo V.	Mishawaka	St. Joseph
Ash, H. H.	W. Lafayette	Tippecanoe	Barron, Elmer A.	East Chicago	Lake
Ashcraft, John R.	Anderson	Madison	Barrow, John H.	Dale	Spencer
Asher, E. O.	New Augusta	Marion	Barry, M. J.	Indianapolis	Marion
Asher, James W.	New Augusta	Marion	Bartholomew, Mary	Goshen	Elkhart
Ashmore, Herbert C.	Hebron	Porter	Bartle, J. Leo	Indianapolis	Marion
Atchison, Kenneth C.	Rockport	Spencer	Bartley, Max D.	Indianapolis	Marion
Atkins, C. C.	Rushville	Rush	Barton, Robert	Angola	Steuben
Atkinson, C. W. (S)	Boswell	Benton	Barton, W. M.	Centerville	Wayne-Union
Aucreman, C. J.	Bluffton	Wells	Bartsch, Harvey L.	South Bend	St. Joseph
Ault, Carl H.	Kokomo	Howard	Bash, Wallace E.	Fort Wayne	Allen
Ault, Roy, Jr.	Terre Haute	Vigo	Baskett, R. J.	Jonesboro	Grant
Aust, Charles H.	Indianapolis	Marion	Bassett, Clancy (S)	Thorntown	Boone
Austin, Charles E.	Anderson	Madison	Bassett, Margaret	Thorntown	Boone
Austin, Eugene W.	Evansville	Vanderburgh	Bassler, C. R.	Mishawaka	St. Joseph
Austin, M. A. (S)	Anderson	Madison	Bates, George	Marion	Grant
Austin, R. P.	Bedford	Lawrence	Batman, Gordon W.	Indianapolis	Marion
Avery, George	Indianapolis	Marion	Battersby, J. Stanley	Indianapolis	Marion
Ayres, Kenneth D.	Anderson	Madison	Batties, Paul A.	Indianapolis	Marion
Ayres, W. W.	Marion	Grant	Bauer, A. J.	Lafayette	Tippecanoe
	B		Bauer, Thomas B.	Indianapolis	Marion
Babb, Forrest J.	Stockwell	Tippecanoe	Baughn, William L.	Anderson	Madison
Bachmann, Arnold J.	Indianapolis	Marion	Baum, Harry	Indianapolis	Marion
Backer, Henry G.	Ferdinand	Dubois	Baumeister, Herbert E.	Indianapolis	Marion
Backs, Alton J.	South Bend	St. Joseph	Baumgartner, Jeraldine	Fort Wayne	Allen
Badders, A. C.	Portland	Jay	Baxter, Harry R.	Seymour	Jackson
Bailey, Edwin B.	Linton	Greene	Baxter, J. W., Jr.	New Albany	Floyd
Bailey, E. W.	Logansport	Cass	Baxter, Neal	Bloomington	Owen-Monroe
Bailey, L. S.	Zionsville	Boone			
Bailey, Orville T.	Indianapolis	Marion	Baxter, Samuel M.	New Albany	Floyd
Bailey, Paul P.	Fort Wayne	Allen	Bayley, William E.	Lafayette	Tippecanoe
Baitinger, H. M.	Gary	Lake	Baylor, Edward M.	Evansville	Vanderburgh
Bakemeier, O. H.	Indianapolis	Marion	Baynes, Frank L.	Wolcott	White
Baker, A. M.	New Albany	Floyd	Beach, Robert R.	Indianapolis	Marion
Baker, G. D.	Crandall	Harrison-Crawford	Beam, Vernon B.	East Chicago	Lake
Baker, Herman	Evansville	Vanderburgh	Beamer, Parker	Indianapolis	Marion
Baker, J. S. (S)	Evansville	Vanderburgh	Beams, Ralph H.	Fort Wayne	Allen
Baker, Leslie M.	Aurora	Dearborn-Ohio	Bean, Joseph S.	Indianapolis	Marion
Baker, Mason R.	Evansville	Vanderburgh	Bear, L. H. (S)	Vevay	Jefferson-Switzerland
Baker, Milan D.	Culver	Marshall			
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Baker, Warren	Michigan City	LaPorte	Beardsley, John	Frankfort	Clinton
Balch, James F.	Indianapolis	Marion	Beasley, T. J.	Indianapolis	Marion
Baldridge, W. O.	Terre Haute	Vigo	Beaver, Ernest R.	Rensselaer	Jasper-Newton
Baldwin, J. H. (S)	Jeffersonville	Clark			
Balkema, Cath. M.	Lafayette	Tippecanoe	Beaver, Howard W.	Indianapolis	Marion
Ball, Clay A.	Muncie	Delaware-Blackford	Beaver, Norman	Berne	Adams
			Bechtol, Lavon D.	Morton Grove, Ill.	Lake
Ball, John R.	Indianapolis	Marion	Bechtold, S. E.	South Bend	St. Joseph
Ball, Joseph E.	Indianapolis	Marion	Beck, David C.	Monticello	White
Ball, Phillip	Muncie	Delaware-Blackford	Beck, Evart M.	Indianapolis	Marion
Ball, T. Z. (S)	Crawfordsville	Montgomery	Beck, H. A.	Lebanon	Boone
Balla, Morris	South Bend	St. Joseph	Beck, Robert E.	Evansville	Vanderburgh
Ballard, C. A.	Logansport	Cass	Becker, Harry G.	Indianapolis	Marion
Ballard, Robert J.	Kirklin	Clinton	Becker, Philip H.	Crown Point	Lake
Ballas, William A.	Evansville	Vanderburgh	Beckes, E. W.	Vincennes	Knox
Ballenger, W. E.	Richmond	Wayne-Union	Beckman, H. F. (S)	Indianapolis	Marion
Balsbaugh, George	N. Manchester	Wabash	Beconovich, Robert	Hammond	Lake
Baltes, Joseph H.	Fort Wayne	Allen	Bedwell, Marion H.	Sullivan	Sullivan
Banister, R. F.	Indianapolis	Marion	Beeler, Franklin K.	Pendleton	Madison
Bankoff, Milton L.	Michigan City	LaPorte	Beeler, J. Moss	Lafayette	Tippecanoe
Banks, H. M.	Indianapolis	Marion	Beeler, John W.	Indianapolis	Marion
Bannon, William G.	Terre Haute	Vigo	Beeler, Raymond C.	Indianapolis	Marion
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Barclay, I. C.	Evansville	Vanderburgh	Begley, Joseph W., Jr.	Evansville	Vanderburgh
Bard, Frank B.	Crothersville	Jackson	Beggs, L. F.	Columbus	Bartholomew-Brown
Barnes, Helen B.	Greenwood	Johnson			
Barnett, R. E.	Peru	Miami	Behn, Walter M.	Gary	Lake
			Behnke, Roy H.	Indianapolis	Marion
			Beierlein, Karl	Fort Wayne	Allen
			Beilke, Clifford A.	East Chicago	Lake



Name	City	County	Name	City	County
Belding, Ray, Jr.	Tipton	Tipton	Blessinger, Louis Henry	Corydon	Harrison-Crawford
Belt, James H.	Indianapolis	Marion	Blessinger, Paul J.	Jasper	Dubois
Benchik, Frank A.	East Chicago	Lake	Blix, Fred M.	Ladoga	Montgomery
Bender, Cecil K.	Goshen	Elkhart	Bloemker, E. F.	Indianapolis	Marion
Bender, Robert L.	Elkhart	Elkhart	Bloom, Asa Ward	Marion	Grant
Bendler, Carl H.	Gary	Lake	Bloom, George R.	Elkhart	Elkhart
Benedek, Tibor	East Chicago	Lake	Bloomer, J. R.	Rockville	Parke-Vermillion
Benedict, Charles D.	LaGrange	LaGrange	Bloomer, R. S.	Rockville	Parke-Vermillion
Benham, L. E.	Bedford	Lawrence	Blosser, B. A.	Fremont	Steuben
Bennett, Abner P.	Evansville	Vanderburgh	Blosser, H. V. (S)	Fort Wayne	Allen
Bennett, J. B.	Warren	Huntington	Blossom, Paul W.	Richmond	Wayne-Union
Bennett, Jene R.	South Bend	St. Joseph	Blum, Leon L.	Terre Haute	Vigo
Benninghoff, D. R.	Fort Wayne	Allen	Boardman, Carl (S)	Gary	Lake
Benoit, Merrill T.	Anderson	Madison	Boaz, John J. (S)	Indianapolis	Marion
Benz, Jesse	Marengo	Harrison-Crawford	Bobb, Kenneth E.	Camp Kilmer, N. J.	Marion
Benz, O. F.	Wanatah	LaPorte	Bock, Don G.	Fort Hood, Texas	Marion
Bergan, Joseph A.	McKinney, Tex.	Lake	Bodnar, Leslie M.	South Bend	St. Joseph
Bergendahl, Emil H.	Fort Wayne	Allen	Bogardus, C. R.	Austin	Scott
Berger, Henry I.	Indianapolis	Marion	Boggs, E. F.	Indianapolis	Marion
Berger, Morley	Beech Grove	Marion	Bohner, C. B.	Indianapolis	Marion
Berghoff, Raymond	Fort Wayne	Allen	Bolin, John T.	Cedar Lake	Lake
Berke, Robert	South Bend	St. Joseph	Bolin, Robert C.	Lafayette	Tippecanoe
Berkebile, J. B.	Peru	Miami	Bolin, Robert S.	Elkhart	Elkhart
Berman, Edward J.	Chicago, Ill.	Marion	Boling, Grover C., Jr.	Indianapolis	Marion
Berman, Jacob K.	Indianapolis	Marion	Bolman, Ralph M.	Fort Wayne	Allen
Bernardi, Hugh	East Chicago	Lake	Bonaventura, A. P.	East Chicago	Lake
Bernoske, D. G.	Michigan City	LaPorte	Bond, Charles S. (S)	Richmond	Wayne-Union
Berton, William M.	Durham, N.C.	Marion	Bond, George S.	Indianapolis	Marion
Best, Robert C.	Whiting	Lake	Bond, Virginia	Indianapolis	Marion
Bethea, Dennis A.	Hammond	Lake	Bond, Walter	Clay City	Clay
Bethea, Robert O.	Farmersburg	Sullivan	Bond, William H.	Indianapolis	Marion
Beutler, Theodore V.	Fort Wayne	Allen	Bonner, Joseph N.	Fort Wayne	Allen
Beverland, M. E.	Indianapolis	Marion	Bonsett, Charles A.	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph	Booher, Norman R.	Indianapolis	Marion
Bibler, Henry E.	Muncie	Delaware-Blackford	Booher, Olga	Indianapolis	Marion
Bibler, L. D.	Indianapolis	Marion	Booth, Boynton H.	Indianapolis	Marion
Bichacoff, Billie D.	Fort Wayne	Allen	Bopp, Henry, Jr.	Terre Haute	Vigo
Bickel, David A.	South Bend	St. Joseph	Bopp, Henry W.	Terre Haute	Vigo
Bickel, J. E. (S)	Fort Wayne	Allen	Bopp, James	Terre Haute	Vigo
Bidney, Evelyn B.	Bloomington	Owen-Monroe	Borak, Walter J.	Gary	Lake
Bigler, Frederick	Goshen	Elkhart	Borders, Theo. R.	Fort Wayne	Allen
Billings, Elmer R.	Elkhart	Elkhart	Boren, Paul	Poseyville	Posey
Billman, Gustus S.	Shelbyville	Shelby	Boren, Samuel W. (S)	Poseyville	Posey
Bills, L. F. (S)	Culver	Marshall	Borenstein, Herschel	Gary	Lake
Bills, R. N.	Gary	Lake	Borland, R. M.	Bloomington	Owen-Monroe
Bird, Chas. R. (S)	Indianapolis	Marion	Borough, L. D.	South Bend	St. Joseph
Birdzell, John P.	Crown Point	Lake	Bosch, Ralph	Seymour	Jackson
Birmingham, P. J.	South Bend	St. Joseph	Bosenbury, Charles S. (S)	South Bend	St. Joseph
Bishop, Charles A.	South Bend	St. Joseph	Bosler, Howard A.	Waterford Mills	Elkhart
Bishop, Harry A.	Frankton	Madison		Mail Goshen	
Bissonnette, Roger P.	Evansville	Vanderburgh	Boswell, Robert W.	Evansville	Vanderburgh
Bitler, C. C.	New Castle	Henry	Botkin, Clyde G.	Muncie	Delaware-Blackford
Bivin, James H.	Mooresville	Morgan	Botkin, Thomas	Muncie	Delaware-Blackford
Bixler, Donald P.	Anderson	Madison	Bottorff, David C.	Charlestown	Clark
Bixler, Louis C.	South Bend	St. Joseph	Boughman, Joseph D.	Kokomo	Howard
Bizer, Mier A.	Cincinnati, O.	Clark	Bowdoin, G. E.	Elkhart	Elkhart
Bjorklund, C. Ray	Hobart	Lake	Bowen, Otis R.	Bremen	Marshall
Black, C. S.	Warren	Huntington	Bowers, Copeland C.	Kokomo	Howard
Black, Charles E.	Hammond	Lake	Bowers, Don D.	Indianapolis	Marion
Black, Edgar K.	Wabash	Wabash	Bowers, G. T.	Fort Wayne	Allen
Black, Joe M.	Seymour	Jackson	Bowers, Garvey B.	Kokomo	Howard
Blackburn, Erwin	South Bend	St. Joseph	Bowers, John A.	Kokomo	Howard
Blackford, Florence	Columbus, O.	Johnson	Bowers, J. W.	Fort Wayne	Allen
Blackford, Milforde	London	Marion	Bowman, Charles M.	Albion	Noble
	England				
Blackwell, Donald	Spencer	Owen-Monroe			
Blassaras, Chris	Anderson	Madison			
Blatt, A. E.	Indianapolis	Marion			
Blazey, A. G.	Washington	Daviess-Martin			
Bledsoe, James G.	New Castle	Henry			
Blemker, Russell M.	Greensburg	Decatur			

Name	City	County	Name	City	County
Bowman, George W.	Indianapolis	Marion	Browning, W. M.	Indianapolis	Marion
Bowman, Harold E.	Pleasant Ridge, Mich.	Marion	Brubaker, Harold S.	Huntington	Huntington
Bowman, Ralph	Columbia City	Whitley	Brubaker, O. G. (S)	N. Manchester	Wabash
Boyd, Charles S.	East Chicago	Lake	Bruce, Reginald A.	Butler	Jennings
Boyd, Clarence E. (S)	West Baden	Orange	Bruegge, T. J.	Kokomo	Howard
Boyd, Stella N.	Evansville	Vanderburgh	Bruetsch, Walter L.	Indianapolis	Marion
Boyer, E. B.	Indianapolis	Marion	Bruggeman, H. O.	Ft. Wayne	Allen
Boyer, Floyd A.	Indianapolis	Marion	Bruner, Ralph	Jeffersonville	Clark
Boyer, Grace B.	Marion	Grant	Brunoehler, Carl J.	Muncie	Delaware-Blackford
Boyer, Philip A.	Indianapolis	Marion	Bryan, F. A.	Ft. Wayne	Allen
Boyle, Carroll	Poseyville	Posey	Bryan, Robert E.	Kendallville	Noble
Boys, F. F.	East Chicago	Lake	Bryan, Robert J.	South Bend	St. Joseph
Boze, Robert L.	Berne	Adams	Bryan, S. L.	Evansville	Vanderburgh
Bradley, Stephen C.	Terre Haute	Vigo	Bryan, Theodore L.	Muncie	Delaware-Blackford
Brady, Samuel	Gary	Lake	Buchanan, W. D.	South Bend	St. Joseph
Brady, Thomas A.	Indianapolis	Marion	Buche, F. P.	Richmond	Wayne-Union
Brandman, Harry	Gary	Lake	Buchholz, Ransom R.	Evansville	Vanderburgh
Brauchla, C. H.	Anderson	Madison	Buck, Charles E.	Indianapolis	Marion
Brauer, Abraham A.	East Chicago	Lake	Buckingham, Richard	Bloomington	Owen-Monroe
Braun, Benjamin D.	Chicago, Ill.	Lake	Buckles, David L.	Anderson	Madison
Braunlin, Robert F.	Marion	Grant	Buckley, E. P.	Jeffersonville	Clark
Braunlin, W. H.	Marion	Grant	Buckman, Robert J.	Charlestown	Clark
Brayton, John R.	Indianapolis	Marion	Buckner, Doster	Ft. Wayne	Allen
Brayton, Lee	Indianapolis	Marion	Buckner, George D.	Fort Wayne	Allen
Brechtol, Harvey J.	South Bend	St. Joseph	Buckner, Joy F.	Bluffton	Wells
Bretz, John M.	Huntingburg	Dubois	Buechler, William F.	Elwood	Madison
Brickley, H. D.	Bluffton	Wells	Buechner, F. W.	South Bend	St. Joseph
Brickley, Richard A.	Indianapolis	Marion	Buehler, George M.	Jeffersonville	Clark
Bridges, William L.	Fort Wayne	Allen	Buehner, Donald F.	Evansville	Vanderburgh
Bridwell, Edgar	Bedford	Lawrence	Buhrmester, H. C.	Lafayette	Tippecanoe
Briggs, Robert W.	Indianapolis	Marion	Buikstra, C. R.	Evansville	Vanderburgh
Brincko, John	Gary	Lake	Bullard, Mattie J.	Gary	Lake
Brink, Calvin C.	Gary	Lake	Bunde, Carl	Indianapolis	Marion
Briscoe, C. E. (S)	New Albany	Floyd	Bunker, L. Z.	N. Manchester	Wabash
Britt, Robert	Evansville	Vanderburgh	Burcham, J. B.	Gary	Lake
Britton, W. D.	Montezuma	Parke-Vermillion	Burdette, Harold r.	Indianapolis	Marion
Brock, Earl E.	Anderson	Madison	Burge, A. D. (S)	Marion	Grant
Brockman, Wilfred	Corydon	Harrison-Crawford	Burger, Robert A.	Gary	Lake
Brockmole, Arnold W.	Evansville	Vanderburgh	Burghard, D. Rolla	Indianapolis	Marion
Brodie, Donald W.	Indianapolis	Marion	Burk, James M.	Decatur	Adams
Bronson, Paul J.	Terre Haute	Vigo	Burket, Cecil R.	Norfolk, Va.	St. Joseph
Brooks, H. L.	Michigan City	LaPorte	Burkhardt, B. A.	Tipton	Tipton
Broomes, Edward L. C.	East Chicago	Lake	Burkle, J. C.	Lafayette	Tippecanoe
Broshears, Kenneth	Linton	Greene	Burks, Jess E.	Crawfordsville	Montgomery
Brosius, Robert H. W.	Ft. Wayne	Allen	Burman, Richard G.	Jeffersonville	Clark
Brown, A. E.	Indianapolis	Marion	Burnett, Arthur B.	New Castle	Henry
Brown, D. B.	Gary	Lake	Burney, Leroy E.	Indianapolis	Marion
Brown, David E.	Indianapolis	Marion	Burnikel, Ray H.	Evansville	Vanderburgh
Brown, Dewitt W.	Indianapolis	Marion	Burns, John T.	Lafayette	Tippecanoe
Brown, Edward A. (S)	Indianapolis	Marion	Burns, Paul E.	Montpelier	Delaware-Blackford
Brown, Frances T.	Indianapolis	Marion	Burress, B. O. (S)	Washington	Daviess-Martin
Brown, Frederic W.	Ft. Wayne	Allen	Burris, F. L.	Michigan City	LaPorte
Brown, George E.	Greenwood	Johnson	Burroughs, C. A.	Frankfort	Clinton
Brown, James A., Sr.	Evansville	Vanderburgh	Burrous, E. Lee	Peru	Miami
Brown, James C.	Valparaiso	Porter	Burwell, Stanley W.	Muncie	Delaware-Blackford
Brown, James M.	Anderson	Madison	Bush, Hargis R.	Cannelton	Perry
Brown, J. S.	Carlisle	Sullivan	Bussard, C. F.	South Bend	St. Joseph
Brown, K. H.	New Albany	Floyd	Bussard, Frank	South Bend	St. Joseph
Brown, Leland G.	Muncie	Delaware-Blackford	Butler, John O.	Indianapolis	Marion
Brown, Leo R.	Gary	Lake	Butler, Robert M.	Indianapolis	Marion
Brown, Marcel S.	Spencer	Owen-Monroe	Butterfield, Robt. M.	Muncie	Delaware-Blackford
Brown, R. E.	Cayuga	Parke-Vermillion	Butts, Milton A.	South Bend	St. Joseph
Brown, Robert M.	Marion	Grant	Buttz, Rose J. (S)	Indianapolis	Marion
Brown, Robert R.	Terre Haute	Vigo	Buxton, Eva (S)	Rockport	Spencer
Brown, Stewart D.	Albany	Delaware-Blackford	Byrn, H. W.	New Albany	Floyd
Brown, Thomas M.	Muncie	Delaware-Blackford	Byrne, John M.	Delphi	Carroll
Brown, Wendell E.	Indianapolis	Marion	Byrne, Robert J.	Bicknell	Knox
Browning, J. S.	Indianapolis	Marion			



Name	City	County	Name	City	County
Cacia, John J.	Evansville	Vanderburgh	Chevigny, J. J.	Gary	Lake
Cahn, Hugo M.	Indianapolis	Marion	Chidlaw, B. W. (S)	Hammond	Lake
Cajacob, Melville E.	Terre Haute	Vigo	Childs, A. G. W. (S)	Madison	Jefferson-Switzerland
Caldwell, Marilyn	Indianapolis	Marion	Childs, Wallace E.	Madison	Jefferson-Switzerland
Caldwell, Milton V.	Terre Haute	Vigo			
Caldwell, William C.	Evansville	Vanderburgh			
Call, Earle B.	Knights town	Henry	Christian, William A.	Indianapolis	Marion
Call, H. F.	Indianapolis	Marion	Christophel, Verna	Mishawaka	St. Joseph
Callaghan, W. C.	Greensburg	Decatur	Chroniak, Walter	Indianapolis	Marion
Callahan, R. H.	East Chicago	Lake	Clancy, J. F.	Hammond	Lake
Calli, Louis	North Vernon	Jennings	Clark, C. P.	Indianapolis	Marion
Calvert, R. R.	Lafayette	Tippecanoe	Clark, Fred O.	Syracuse	Kosciusko
Calvin, Jessie C. (S)	Ft. Wayne	Allen	Clark, Ivan A.	Paoli	Orange
Cameron, D. F.	Ft. Wayne	Allen	Clark, Lawson J.	Indianapolis	Marion
Cameron, Mary H.	Angola	Steuben	Clark, M. E.	Cambridge City	Wayne-Union
Campagna, E. A.	East Chicago	Lake			
Campbell, Guy G.	Munster	Lake	Clark, Stanley A. (S)	South Bend	St. Joseph
Campbell, J. A.	Indianapolis	Marion	Clark, William B., Jr.	Jeffersonville	Clark
Campbell, P. A.	Richmond	Wayne-Union	Clark, Wm. H.	South Bend	St. Joseph
Campbell, Sam W.	Noblesville	Hamilton	Clark, W. R.	Ft. Wayne	Allen
Canaday, C. E. (S)	New Castle	Henry	Clarke, Elton R.	Kokomo	Howard
Canaday, J. W. (S)	Indianapolis	Marion	Clauser, E. H.	Muncie	Delaware-Blackford
Canganelli, Vincent G.	Ingleside, Neb.	Marion			
Caplin, Irvin	Aspinwall, Pa.	Marion	Clements, A. F.	Evansville	Vanderburgh
Caplin, S. S.	Indianapolis	Marion	Cleveland, John B.	Michigan City	LaPorte
Carberry, George A.	Gary	Lake	Clevenger, J. H.	Muncie	Delaware-Blackford
Carbone, J. A.	Gary	Lake			
Carey, W. W. (S)	Ft. Wayne	Allen	Clevinger, Wm. G.	Indianapolis	Marion
Carlberg, D. L.	Jeffersonville	Clark	Cline, Kenneth L.	Wyatt	St. Joseph
Carleton, E. H.	East Chicago	Lake	Close, W. D.	Indianapolis	Marion
Carlo, Ernest R.	Ft. Wayne	Allen	Clouse, Paul A.	Evansville	Vanderburgh
Carlo, J. F.	Hammond	Lake	Clunie, Wm. A.	Huntington	Huntington
Carlson, Charles E.	Chicago, Ill.	Marion	Coble, F. H.	Richmond	Wayne-Union
Carlson, E. A. (S)	Peru	Miami	Coble, R. R. (S)	Indianapolis	Marion
Carlson, Norman C.	Michigan City	LaPorte	Cochran, Harry A., Jr.	Fort Wayne	Allen
Carlyle, Ivan E.	Michigantown	Clinton	Cockrum, Wm. M.	Evansville	Vanderburgh
Carmony, R. F.	Gary	Lake	Coddens, A. L.	Earl Park	Benton
Carneal, Thomas E.	Winamac	Pulaski	Cody, B. L.	Evansville	Vanderburgh
Carney, J. T.	Jeffersonville	Clark	Coffel, Melvin H.	Vincennes	Knox
Carney, John C.	Monticello	White	Coffman, Delmar Lee	Clinton, Okla.	Vanderburgh
Carpenter, J. L.	Alexandria	Madison	Coggeshall, Warren E.	Indianapolis	Marion
Carpentier, Harry F.	Princeton	Gibson	Cohn, Alvin C.	Indianapolis	Marion
Carrel, Francis E.	Frankfort	Clinton	Cohen, Irving	Plainfield	Hendricks
Carroll, Bertha Rose	W. Lafayette	Tippecanoe	Cole, A. V.	East Chicago	Lake
Carroll, John C.	Decatur	Adams	Cole, Ira	Lafayette	Tippecanoe
Carroll, Mary E.	Crown Point	Lake	Coleman, Floyd B.	Waterloo	Dekalb
Carson, Wayne	Indianapolis	Marion	Coleman, H. G.	Odon	Daviess-Martin
Carter, F. R. Nicholas	South Bend	St. Joseph			
Carter, Fred S.	LaPorte	LaPorte	Coleman, Joseph E.	Evansville	Vanderburgh
Carter, J. V.	Tipton	Tipton	Coleman, William S. (S)	Carthage	Rush
Carter, Oren E.	Indianapolis	Marion	Colglazier, G. G. (S)	Leipsic	Orange
Cartwright, E. L.	Ft. Wayne	Allen	Colip, George	South Bend	St. Joseph
Cartwright, Jack D.	LaPorte	LaPorte	Collins, Hubert L.	Indianapolis	Marion
Casebeer, P. B.	Clinton	Parke-Vermillion	Collins, J. N.	Indianapolis	Marion
			Combs, Charles N. (S)	Terre Haute	Vigo
Casey, Stanley M.	Huntington	Huntington	Combs, Herman	Evansville	Vanderburgh
Cassady, J. V.	South Bend	St. Joseph	Combs, John H.	Evansville	Vanderburgh
Cavins, A. W.	Terre Haute	Vigo	Combs, Loyal W.	Hobart	Lake
Caylor, Harold D.	Bluffton	Wells	Combs, Nelson B.	Mulberry	Clinton
Caylor, Truman E.	Bluffton	Wells	Combs, Pearl B.	Evansville	Vanderburgh
Challman, W. B.	Mt. Vernon	Posey	Combs, Stuart R.	Terre Haute	Vigo
Chambers, A. R.	Ft. Wayne	Allen	Comeau, Wm. J.	Marion	Grant
Chambers, L. B.	Union City	Randolph	Comer, Charles W.	Mooresville	Morgan
Champion, John P.	Indianapolis	Marion	Comer, Kenneth E.	Mooresville	Morgan
Chandler, L. H.	Goshen	Elkhart	Compton, C. B.	Los Angeles, Calif.	Clinton
Chappel, Alfred T.	Franklin	Johnson			
Chappell, Harold R.	Oakland City	Gibson	Compton, George	Tipton	Tipton
Chattin, Herbert O.	Vincennes	Knox	Compton, Walter A.	Elkhart	Elkhart
Chattin, Robert E.	Loogootee	Daviess-Martin	Condit, David H.	South Bend	St. Joseph
Chattin, William R.	Indianapolis	Marion	Congleton, G. C.	Terre Haute	Vigo
Chattin, V. J.	Washington	Daviess-Martin	Conklin, James O.	Terre Haute	Vigo
Cheydeur, Eleanor	Evansville	Vanderburgh	Conklin, R. L.	Elkhart	Elkhart
Chen, K. K.	Indianapolis	Marion	Conley, John E.	Ft. Wayne	Allen
			Conley, Joseph L.	Indianapolis	Marion



Name	City	County	Name	City	County
Conley, T. M.	Kokomo	Howard	Crowder, James H., Jr.	Sullivan	Sullivan
Connell, P. S.	Plymouth	Marshall	Crum, Marion M.	Angola	Steuben
Connell, Vactor O.	Bourbon	Marshall	Culbertson, C. S.	South Bend	St. Joseph
Connerley, M. L.	San Diego, Calif.	Marion	Culbertson, Clyde G.	Indianapolis	Marion
Connoy, Andrew F.	Westfield	Hamilton	Cullen, P. K.	Indianapolis	Marion
Connoy, Leo	Westfield	Hamilton	Cullison, Charles W.	Vincennes	Knox
Conrad, E. M. (S)	Anderson	Madison	Cullnane, C. W.	Evansville	Vanderburgh
Conrad, Henry W.	Milan	Ripley	Culloden, William G.	Indianapolis	Marion
Conway, Chester C.	Indianapolis	Marion	Culmer, W. N. (S)	Bloomington	Owen- Monroe
Conway, Glenn	Indianapolis	Marion			
Cook, C. J. (S)	Indianapolis	Marion	Culp, John E.	Ft. Wayne	Allen
Cook, Charles E.	North Manchester	Wabash	Cummings, D. J. (S)	Brownstown	Jackson
Cook, Elbert C. (S)	Bradenton, Fla.	Jefferson- Switzerland	Cure, Charles W.	Ft. Campbell, Ky.	Marion
Cook, G. M.	Hammond	Lake	Cure, Elmer T.	Muncie	Delaware- Blackford
Cook, Gordon C.	South Bend	St. Joseph	Currie, Robert W.	Marion	Grant
Cook, Norman R.	Richmond	Wayne-Union	Curry, Claude A.	Terre Haute	Vigo
Cook, Robert G.	Bluffton	Wells	Curtner, M. L.	Vincennes	Knox
Cooksey, T. L. (S)	Crawfordsville	Montgomery	Custer, E. W.	South Bend	St. Joseph
Cooney, Charles J.	Ft. Wayne	Allen	Cuthbert, M. P.	Indianapolis	Marion
Coons, John D.	Lebanon	Boone	Cutshaw, James A.	Monroeville	Allen
Coons, Ritchie	Lebanon	Boone	Czenkusch, Helen G.	Indianapolis	Marion
Cooper, H. L.	South Bend	St. Joseph		D	
Cooper, Leo Kenneth	Gary	Lake	Daggy, James R.	Richmond	Wayne-Union
Cooper, Thomas L.	Logansport	Cass	Dagley, Hubert	Greenwood	Johnson
Cope, Stanton E.	Huntington	Huntington	Dahling, C. W.	New Haven	Allen
Copeland S. J. (S)	Indianapolis	Marion	Dainko, A. J.	East Chicago	Lake
Copcoran, Patrick J. V.	Evansville	Vanderburgh	Dale, J. W.	Chesterton	Porter
Cormican, Herbert L.	Elkhart	Elkhart	Dale, Maxwell H.	Connersville	Fayette- Franklin
Cornacchione, M.	Indianapolis	Marion			
Cornell, Beaumont S.	Ft. Wayne	Allen	Daley, Edward H.	Oldenburg	Ripley
Cornell, Robert A.	Crawfordsville	Montgomery	Dalton, John E.	Indianapolis	Marion
Corpe, Kenneth F.	Rushville	Rush	Dalton, Naomi	Houston, Tex.	Owen- Monroe
Corrao, Gaetano	East Chicago	Lake			
Corsentino, Bart	Vincennes	Knox	Dalton, William W.	Indianapolis	Marion
Cortese, James V.	Indianapolis	Marion	Dalton, Wilson L.	Shelbyville	Shelby
Cortese, Thomas A.	Indianapolis	Marion	Daly, Joseph M.	Indianapolis	Marion
Cotter, E. R.	East Chicago	Lake	Damiana, Pasquale G.	Peru	Miami
Coulson, S. B. (S)	Waldron	Shelby	Dancer, C. R. (S)	Fort Wayne	Allen
Coultas, P. J.	Tell City	Perry	Dando, George H. (S)	Hartford City	Delaware- Blackford
Countryman, Frank W.	Indianapolis	Marion			
Coursey, James O.	Goodland	Jasper- Newton	Daniel, J. C.	Indianapolis	Marion
			Danieleski, L. J.	Gary	Lake
Courtney, John W.	Indianapolis	Marion	Daniels, E. O.	Marion	Grant
Covalt, Wendell E.	Muncie	Delaware- Blackford	Daniels, G. R. (S)	Marion	Grant
			Danielson, Harry E., Jr.	Plymouth	Marshall
Covell, H. M.	Auburn	Dekalb	Dannacher, William D.	Wabash	Wabash
Cox, C. E.	Indianapolis	Marion	Dare, Lee A.	Jeffersonville	Clark
Cox, Leon T.	Richmond	Wayne-Union	Darling, Dorothy	Gary	Lake
Cox, W. T.	Lafayette	Tippecanoe	Darroch, S. C.	Cayuga	Parke- Vermillion
Coyner, A. B.	Lafayette	Tippecanoe			
Craft, K. L.	Indianapolis	Marion	Dassel, Paul Milton	Maywood, Ill.	Lake
Craft, William F.	Linton	Greene	Datzman, Richard C.	Fort Wayne	Allen
Craig, Alexander F.	New Castle	Henry	Daubenhayer, M. F. (S)	Butlerville	Jennings
Craig, R. A.	Kokomo	Howard	Daugherty, F. N.	Crawfordsville	Montgomery
Craig, Reuben	Kokomo	Howard	Daves, W. L.	Evansville	Vanderburgh
Craig, Robert A.	Syracuse	Kosciusko	Davidoff, Manuel A.	Ossian	Wells
Crain, James Wm.	Williamsport	Fountain- Warren	Davidson, Dale A.	Indianapolis	Marion
			Davidson, N. Cort	Indianapolis	Marion
Crampton, C. C. (S)	Delphi	Carroll	Davies, Robert	New Castle	Henry
Crandall, Latham A.	Elkhart	Elkhart	Davis, Alice H.	Hammond	Lake
Craven, Howard	Indianapolis	Marion	Davis, Carl M.	Valparaiso	Porter
Crawford, James H.	Evansville	Vanderburgh	Davis, Claude E.	Milltown	Harrison- Crawford
Crawford, John A.	Indianapolis	Marion			
Crawford, Robert	South Bend	St. Joseph	Davis, E. C.	Muncie	Delaware- Blackford
Crawford, T. R.	Kokomo	Howard			
Creel, Donald	Angola	Steuben	Davis, Howard B.	Rock Hill, Mo.	Knox
Crevello, Albert J.	Evansville	Vanderburgh			
Crimm, Paul D.	Sidney, Ohio	Vanderburgh	Davis, J. A.	Flat Rock	Shelby
Cring, George	Portland	Jay	Davis, John A.	Indianapolis	Marion
Cripe, E. P.	Bremen	Marshall	Davis, John C.	Logansport	Cass
Cripe, William	Portland	Jay	Davis, Joseph B.	Marion	Grant
Crockett, F. S.	Lafayette	Tippecanoe	Davis, M. S.	Marion	Grant
Crossland, Stewart H.	Gary	Lake			

Name	City	County	Name	City	County
Davis, Marvin R.	Columbus	Bartholomew-Brown	Dintaman, Paul G.	Indianapolis	Marion
Davis, Merle J.	Terre Haute	Vigo	Dirks, Kenneth R.	Indianapolis	Marion
Davis, Neal	Gary	Lake	Dittmer, J. E.	Valparaiso	Porter
Davis, Parvin M.	New Albany	Floyd	Dittmer, Thomas L.	Valparaiso	Porter
Davis, Richard	Marion	Grant	Ditton, I. W. (S)	Ft. Wayne	Allen
Davis, Sam J.	Indianapolis	Marion	Dixon, Rex	Anderson	Madison
Davis, William	New Market	Montgomery	Dobbs, O. R.	Greencastle	Putnam
Day, W. D. C.	Seymour	Jackson	Dodd, Robert D.	South Bend	St. Joseph
Deal, Eleanor H.	Speedway City	Marion	Dodd, Roberts K.	Evansville	Vanderburgh
Dean, Donald I.	Rushville	Rush	Dodds, James U.	Hartford City	Delaware-Blackford
Dearmin, R. M.	Indianapolis	Marion	Dodds, Wemple	Crawfordsville	Montgomery
DeArmond, Murray	Indianapolis	Marion	Doenges, James L.	Anderson	Madison
Decker, H. B.	Terre Haute	Vigo	Dolezal, Bernard J.	South Bend	St. Joseph
DeDario, L. M.	Elkhart	Elkhart	Dollens, Claude	Oolitic	Lawrence
Deems, Myers B.	Evansville	Vanderburgh	Dome, H. S. (S)	Tell City	Perry
Deer, Blan F.	Lake Worth, Fla.	Marion	Donahue, C. M.	Carmel	Hamilton
Deever, J. W.	Indianapolis	Marion	Donahue, G. R.	Lafayette	Tippecanoe
DeFries, John J.	New Paris	Elkhart	Donaldson, Frank C.	Anderson	Madison
DeGrazia, E. J.	Valparaiso	Porter	Donato, Albert M.	Indianapolis	Marion
DeMotte, C. Bowen	Indianapolis	Marion	Donchess, J. C.	Gary	Lake
DeMotte, Russell A.	Bloomington	Owen-Monroe	Donham, William L.	Bicknell	Knox
DeNaut, J. F.	Knox	Starke	Donnelly, Everett F.	South Bend	St. Joseph
Denham, Robert H.	South Bend	St. Joseph	Doran, J. Hal	Indianapolis	Marion
Denman, R. D. (S)	Helmer	Steuben	Dorman, W. L.	Indianapolis	Marion
Denny, Edgar C.	Milton	Wayne-Union	Dorrance, T. O.	Bluffton	Wells
Denny, Fred C.	Madison	Jefferson-Switzerland	Doty, J. R.	Gary	Lake
Denny, Forrest L.	Indianapolis	Marion	Douglas, G. R. (S)	Valparaiso	Porter
Denny, Frank T.	Ladoga	Montgomery	Douglas, William T.	Montpelier	Delaware-Blackford
Denny, J. W.	Indianapolis	Marion	Dovey, Edward G.	Elkhart	Elkhart
Denny, Melvin H.	Rushville	Rush	Dowd, Joseph A.	Indianapolis	Marion
Denton, Larkin D.	Greentown	Howard	Dowell, E. H.	Rockville	Parke-Vermillion
Denzer, E. K.	Evansville	Vanderburgh	Downard, Leland F.	Gaston	Delaware-Blackford
Denzer, Wm. Oliver	Evansville	Vanderburgh	Dragoo, Farrol	Middletown	Henry
Deppe, Charles F.	Franklin	Johnson	Drake, John C.	Anderson	Madison
Derhammer, G. L.	Brookston	White	Drake, M. C.	Elwood	Madison
DesJean, Paul A.	Indianapolis	Marion	Draper, M. H.	St. Petersburg, Fla.	Allen
Dest, Paul	Lansing, Ill.	Lake	Dreyer, Ralph W.	Knightstown	Henry
Dester, Herbert E.	Jagdeeshpur, India	Marion	Dryden, Gale E.	Covena, Calif.	Marion
DeTar, G. B. (S)	Winslow	Pike	Dublin, Madeline P.	Francesville	Pulaski
Detrick, H. W.	Alamo, Tex.	Lake	DuBois, Charles C. (S)	Warsaw	Kosciusko
Dettloff, Frederick	Greencastle	Putnam	Dubois, F. T. (S)	Liberty	Wayne-Union
Deutsch, Wm.	Muncie	Delaware-Blackford	Dubois, R. B.	Lafayette	Tippecanoe
DeVoe, Kenneth	Butler	DeKalb	Duckworth, Alda G.	Van Nuys, Calif.	Marion
DeWees, Dwight L.	Indianapolis	Marion	Dudding, J. E.	Hope	Bartholomew-Brown
Dewey, Fred N. (S)	Maumee, O.	Elkhart	Duemling, Arnold H.	Ft. Wayne	Allen
Dewey, Geo. W. (S)	Lafayette	Tippecanoe	Duffield, John R.	Charlestown	Clark
DeWitt, C. H. (S)	Valparaiso	Porter	Dugan, Thomas J. (S)	Indianapolis	Marion
Diamond, Leo	Marion	Grant	Dugan, Wm. M.	Indianapolis	Marion
Dian, A. J.	Gary	Lake	Duggan, J. A.	South Bend	St. Joseph
Dian, Julia G. Kuzmitz	Gary	Lake	Dukes, Betty	Dugger	Sullivan
Dickerson, William M.	Lafayette	Tippecanoe	Dukes, David A.	Tell City	Perry
Dickey, William M.	Pendleton	Madison	Dukes, F. M.	Dugger	Sullivan
Dickson, D. D.	Greensburg	Decatur	Dukes, Joe E.	Dugger	Sullivan
Dickinson, Gordon A.	Petersburg	Pike	Dulin, Basil B.	Indianapolis	Marion
Dieckman, Herbert S.	Evansville	Vanderburgh	Dunbar, Colin V.	Indianapolis	Marion
Diefendorf, Charles F. (S)	Evansville	Vanderburgh	Duncan, J. S.	Gary	Lake
Dielman, F. C.	Fulton	Fulton	Duncan, Raymond	Bedford	Lawrence
Dierdorf, Fred	Winslow	Pike	Dunlap, D. Logan	South Bend	St. Joseph
Dierolf, Edward J.	Gary	Lake	Dunn, F. W.	Muncie	Delaware-Blackford
Dietl, E. L.	South Bend	St. Joseph	Dunning, L. M.	Indianapolis	Marion
Dill, Myron K.	Indianapolis	Marion	Dunstone, H. C.	Ft. Wayne	Allen
Dillman, Carl E.	Corydon	Harrison-Crawford	Dupes, L. E.	Indianapolis	Marion
Dilts, Robert	Indianapolis	Marion	DuPuy, Charles M. (S)	Riley	Vigo
Dimmett, Robert P.	Boonville	Warrick	Durham, Lowell J.	LaPorte	LaPorte
Dingle, Paul	Richmond	Wayne-Union	Durkee, M. S.	Evansville	Vanderburgh
Dininger, W. S.	Winchester	Randolph	Dusard, Joseph C.	Bedford	Lawrence
			DuSold, Donald D.	Crown Point	Lake



Name	City	County	Name	City	County
Dutchess, C. T.	Galveston	Cass	Endicott, Wayne	Greenfield	Hancock
DuVall, William N.	Mishawaka	St. Joseph	Engel, E. L.	Evansville	Vanderburgh
Dyar, E. W.	Indianapolis	Marion	Engeler, J. E.	Lafayette	Tippecanoe
Dycus, W. A.	Evansville	Vanderburgh	Engle, Russell B.	Winchester	Randolph
Dyer, G. W.	Terre Haute	Vigo	Engleman, H. K. (S)	Georgetown	Floyd
Dyer, Wallace K.	Evansville	Vanderburgh	English, H. M.	Gary	Lake
Dyke, Richard W.	Indianapolis	Marion	English, J. P.	South Bend	St. Joseph
Dykhuizen, T. A.	Frankfort	Clinton	Ensminger, L. A. (S)	Indianapolis	Marion
	E		Entner, Charles L.	Connersville	Fayette-Franklin
Eades, R. Charles	Valparaiso	Porter	Enzor, O. K.	Indianapolis	Marion
Eades, Ralph C.	Valparaiso	Porter	Episcopo, A. R.	Salem	Washington
Earl, Max M.	Kokomo	Howard	Erdel, Milton W.	Frankfort	Clinton
Earp, Evanson B.	Indianapolis	Marion	Erehart, A. D.	Anderson	Madison
Eastman, J. R., Jr.	Highland		Erehart, M. G.	Huntington	Huntington
	Park, Mich.	Marion	Eriksen, Lester G.	South Bend	St. Joseph
Eaton, E. R.	Indianapolis	Marion	Erickson, Gustaf W.	South Bend	St. Joseph
Eaton, L. D.	Greenwood	Johnson	Ericson, H. L.	Windfall	Tipton
Eaton, M. J.	Lafayette	Tippecanoe	Ernst, Clifford	Indianapolis	Marion
Ebbinghouse, Tom	Richmond	Wayne-Union	Ernst, H. C.	East Chicago	Lake
Ebert, J. Wayne	Indianapolis	Marion	Erxleben, Walter O.	Batesville	Ripley
Eberwein, J. H.	Indianapolis	Marion	Espy, Theodore R.	Gary	Lake
Ebin, Judah L.	South Bend	St. Joseph	Estes, Ambrose C.	Bloomington	Owen-Monroe
Eby, Ida L.	Goshen	Elkhart			
Echsner, Herman J.	Columbus	Bartholomew-Brown	Evans, Frederick H.	Indianapolis	Marion
			Evans, Frederick J.	Clinton	Parke-Vermillion
Eckert, Russell A.	Chicago, Ill.	Marion			
Eckles, Donald H.	Charlestown	Clark	Evans, Paul V.	Indianapolis	Marion
Edlavitch, B. M.	Ft. Wayne	Allen	Evans, R. M.	Russaviile	Howard
Edmonds, Kendrick	Bedford	Lawrence	Everly, Ralph	Indianapolis	Marion
Edwards, Bernard	South Bend	St. Joseph	Eviston, J. V.	Huntington	Huntington
Edwards, Edward T., Jr.	Vincennes	Knox	Ewbank, J. Nelson	Richmond	Wayne-Union
Edwards, W. F.	New Albany	Floyd	Ewing, Nathaniel D.	Vincennes	Knox
Egan, Sherman	South Bend	St. Joseph			
Egbert, Herbert	Indianapolis	Marion		F	
Eggers, E. L.	Hammond	Lake	Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio
Eggers, H. W.	Hammond	Lake			
Egnatz, Nicholas	Hammond	Lake	Failey, Robert	Indianapolis	Marion
Ehrich, W. S.	Evansville	Vanderburgh	Faith, I. L.	Newburgh	Warrick
Ehrman, C. D. (S)	Rockport	Spencer	Faltin, Ladislaus	South Bend	St. Joseph
Eicher, Palmer	Indianapolis	Marion	Fargher, F. M.	Michigan City	La Porte
Eickenberry, H. W.	Indianapolis	Marion	Fargher, R. A.	La Porte	La Porte
Eisaman, Jack L.	Bluffton	Wells	Farner, James E.	Mishawaka	St. Joseph
Eisenberg, D. A.	Martinsville	Morgan	Farnsworth, S. A.	La Porte	La Porte
Eisterhold, John A.	Evansville	Vanderburgh	Farr, James	Martinsville	Morgan
Eldridge, Gail E.	Indianapolis	Marion	Farrell, J. T.	Indianapolis	Marion
Elledge, Ray	Hammond	Lake	Farris, John J.	Washington	Daviess-Martin
Ellerbrook, George E.	Vevay	Jefferson-Switzerland			
			Faul, Henry J.	Evansville	Vanderburgh
Ellett, John, Jr.	Coatesville	Hendricks	Faulkner, W. H.	Nashville, Tenn.	Wayne-Union
Elliott, John C.	Guilford	Dearborn-Ohio			
			Fausset, C. Basil	Indianapolis	Marion
Elliott, L. A.	Elkhart	Elkhart	Feerer, Donald J.	Michigan City	La Porte
Elliott, Paul W.	Danville	Hendricks	Feferman, Martin E.	South Bend	St. Joseph
Elliott, R. A.	Gary	Lake	Feinn, Harry S.	LaPorte	LaPorte
Elliott, Thomas A.	Elkhart	Elkhart	Feldman, Max	South Bend	St. Joseph
Ellis, Bert	Indianapolis	Marion	Fender, A. H.	Worthington	Greene
Ellis, Davis W., Jr.	Rushville	Rush	Fenneman, Robert J.	Evansville	Vanderburgh
Ellis, George M.	Connersville	Fayette-Franklin	Ferguson, A. N.	Fort Wayne	Allen
			Ferguson, John T.	Logansport	Cass
Ellis, Lyman H.	Lizton	Hendricks	Ferguson, Wm. B.	W. Lafayette	Tippecanoe
Ellis, Seth	Anderson	Madison	Ferrara, Donald W.	Peru	Miami
Ellis, William N.	Indianapolis	Marion	Ferrara, Joseph F.	Franklin	Johnson
Ellison, Alfred	South Bend	St. Joseph	Ferrara, S. J.	Peru	Miami
Elshout, Clem H.	LaPorte	LaPorte	Ferry, Francis A.	Beech Grove	Marion
Elsner, L. W.	Seymour	Jackson	Ferry, John L.	Whiting	Lake
Elsten, A. W.	Anderson	Madison	Ferry, P. W.	Kokomo	Howard
Elston, L. W.	Ft. Wayne	Allen	Fessler, G. S.	Rising Sun	Dearborn-Ohio
Elston, Ralph W.	Ft. Wayne	Allen			
Elward, Carl J.	Wabash	Wabash	Fichman, A. M.	Fort Wayne	Allen
Emenhiser, Donald C.	Woodburn	Allen	Fickas, Dallas	Evansville	Vanderburgh
Emenhiser, John L.	Fort Wayne	Allen	Fields, Don	Indianapolis	Marion
Emery, Charles B.	Bedford	Lawrence	Filipek, W. J.	South Bend	St. Joseph
Emhardt, J. W. A.	Indianapolis	Marion	Finfrock, James D.	Indianapolis	Marion
Emhardt, John T.	Indianapolis	Marion	Fipp, August L.	Rome City	Noble
Emme, R. W.	Harlan	Allen	Firestein, Ben	South Bend	St. Joseph



Name	City	County	Name	City	County
Firestein, Ray	South Bend	St. Joseph	Freed, John E., Sr.	Terre Haute	Vigo
Fisch, Charles	Indianapolis	Marion	Freed, John E., Jr.	Terre Haute	Vigo
Fischer, Albert A.	Indianapolis	Marion	Freeman, F. M.	Goshen	Elkhart
Fischer, Burnell	Hammond	Lake	Freeman, Max E.	Indianapolis	Marion
Fischer, C. N.	La Porte	La Porte	Frey, Harley B.	Lafayette	Tippecanoe
Fischer, W. E.	Anderson	Madison	Frey, William B.	South Bend	St. Joseph
Fish, C. M. (S)	South Bend	St. Joseph	Friedman, David K.	Houston, Tex.	Marion
Fish, Edson C.	South Bend	St. Joseph	Friedman, Isadore E.	Hammond	Lake
Fisher, Gerald	Cleveland, O.	Marion	Friedman, Morris S.	South Bend	St. Joseph
Fisher, Henry	Marion	Grant	Friedrich, Louis M. (S)	Hobart	Lake
Fisher, John E.	Attica	Fountain-Warren	Frith, Gladys D.	South Bend	St. Joseph
Fisher, John E.	New Castle	Henry	Frith, Louis G.	South Bend	St. Joseph
Fisher, Lawrence F.	South Bend	St. Joseph	Fritsch, L. E. (S)	Evansville	Vanderburgh
Fisher, Walter S.	Columbus	Bartholomew-Brown	Fromhold, Willis A.	Indianapolis	Marion
Fisher, William C.	Evansville	Vanderburgh	Frost, Robert J.	Michigan City	LaPorte
Fitzgerald, Brice E.	Logansport	Cass	Fruth, Rodney B.	Connersville	Fayette-Franklin
Fitz Gerald, Maurice D.	Evansville	Vanderburgh	Fruth, Virgil T.	Connersville	Fayette-Franklin
Fitzgerald, William J.	Indianapolis	Marion	Fry, Robert D.	Indianapolis	Marion
Fitzpatrick, Harry W.	Elwood	Madison	Frybarger, S. S.	Converse	Miami
Fitzpatrick, James S.	Portland	Jay	Fullerton, R. L.	Indianapolis	Marion
Fitzsimmons, E. L.	Evansville	Vanderburgh	Fultz, Roy L.	Indianapolis	Marion
Flack, Russell A.	Lafayette	Tippecanoe	Funk, John W.	Muncie	Delaware-Blackford
Flaherty, Walter T.	Michigan City	La Porte	Funkhouser, Elmer	Indianapolis	Marion
Flanagan, E. P.	Walton	Cass	Fuqua, Harold B.	Terre Haute	Vigo
Flanigan, M. B.	Indianapolis	Marion	Furgason, Paul C.	Indianapolis	Marion
Flannigan, H. F.	LaGrange	LaGrange	Fuson, W. J.	Greencastle	Putnam
Fleetwood, R. A.	Nappanee	Elkhart	Futterknecht, James O.	Elkhart	Elkhart
Fleischer, J. C.	East Chicago	Lake	G		
Fleming, C. F.	Elkhart	Elkhart	Gabe, Wm. E.	Indianapolis	Marion
Fleming, Justus M.	Elkhart	Elkhart	Gaddy, Euclid T.	Indianapolis	Marion
Fletcher, Charles F.	Sunman	Ripley	Gailey, Ivan	Poseyville	Posey
Flick, John J.	Indianapolis	Marion	Galante, Vincent J.	Chicago, Ill.	Lake
Flora, Joseph O.	Indianapolis	Marion	Galbreath, R. S.	Huntington	Huntington
Folck, J. K.	Princeton	Gibson	Galbreath, J. P. (S)	Burnettsville	White
Folkening, N. C.	Indianapolis	Marion	Galliher, Marjorie J.	Muncie	Delaware-Blackford
Foltz, Lloyd E.	Brownsburg	Hendricks	Gallup, Palmer R.	Indianapolis	Marion
Forbes, Violet Crabbe	Wolcott	White	Gambill, Wm. D.	Indianapolis	Marion
Foreman, Harry L.	Indianapolis	Marion	Gammieri, Robert L.	Indianapolis	Marion
Foreman, Walter A.	Brookville	Fayette-Franklin	Gannon, G. W. (S)	Gary	Lake
Forry, Frank	Indianapolis	Marion	Ganser, Richard A.	Mishawaka	St. Joseph
Forsee, Norman E.	Jeffersonville	Clark	Gante, H. W.	Anderson	Madison
Forsyth, D. H. (S)	Terre Haute	Vigo	Ganz, Max	Marion	Grant
Fosbrink, E. L.	Syracuse	Kosciusko	Garber, E. C.	Dunkirk	Jay
Fosgate, Orville E.	Briggs, A.F.B., Tex.	Marion	Garber, J. Neill	Indianapolis	Marion
Foster, Lee N.	Indianapolis	Marion	Garceau, George J.	Indianapolis	Marion
Foster, Ray T.	New Castle	Henry	Gard, Daniel A.	Marshall	Parke-Vermillion
Foster, Robert	Franklin	Johnson	Gardiner, H. Glenn	East Chicago	Lake
Fontaine, Thomas J.	Bedford	Lawrence	Gardiner, Sprague H.	Indianapolis	Marion
Fouts, Paul J.	Indianapolis	Marion	Gardner, Buckman	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe	Gardner, M. D.	Michigan City	La Porte
Fox, C. Philip	Washington	Daviess-Martin	Gardner, Russell A.	Michigan City	La Porte
Fox, Maurice S.	Vincennes	Knox	Garfield, M. D.	Indianapolis	Marion
Fox, R. H. (S)	Bicknell	Knox	Garland, Edgar	Evansville	Vanderburgh
Foy, H. W.	Fort Wayne	Allen	Garling, L. C.	Muncie	Delaware-Blackford
Frank, J. R.	Valparaiso	Porter	Garner, William (S)	Indianapolis	Marion
Frank, L. L.	South Bend	St. Joseph	Garner, W. Stanley	Indianapolis	Marion
Franklin, John W.	Muncie	Delaware-Blackford	Garner, Wm. H., Jr.	New Albany	Floyd
Franklin, William L.	Indianapolis	Marion	Garner, Wm. H.	New Albany	Floyd
Frankowski, Clementine	Whiting	Lake	Garrett, John D. (S)	Indianapolis	Marion
Frantz, Mount E.	Danville	Hendricks	Garrett, Robert A.	Indianapolis	Marion
Frasch, M. G.	Lafayette	Tippecanoe	Garrison, James L.	Cumberland	Marion
Frash, De Von W.	South Bend	St. Joseph	Garrison, Leon J.	Gas City	Grant
Frazin, Bernard	Indianapolis	Marion	Garton, H. W.	Ft. Wayne	Allen
Freeborn, Warren S.	New York, N. Y.	Marion	Gastineau, David C.	Indianapolis	Marion
Freed, Carl A.	Attica	Fountain-Warren	Gastineau, F. M.	Indianapolis	Marion
Freed, James C.	Attica	Fountain-Warren	Gatch, W. D.	Indianapolis	Marion
			Gates, George E.	South Bend	St. Joseph
			Gattman, George B.	Indianapolis	Marion
			Gaul, L. Edward	Evansville	Vanderburgh

Name	City	County	Name	City	County
Gaunt, Everett W.	Alexandria	Madison	Goldstone, Adolph	Gary	Lake
Geckler, Charles E.	Muncie	Delaware- Blackford	Goldstone, Harry A.	South Bend	St. Joseph
Gehres, R. W.	Shelbyville	Shelby	Goldstone, Joseph	Gary	Lake
Geick, Raymond	Fort Branch	Gibson	Goldstone, S. R.	Gary	Lake
Geider, Roy A.	Indianapolis	Marion	Golper, Marvin N.	Kokomo	Howard
Geiger, Dillon	Bloomington	Owen- Monroe	Good, R. P.	Kokomo	Howard
Geller, Samuel	Owensville	Gibson	Goodman, Eli	Charlestown	Clark
Genna, Mary E.	Indianapolis	Marion	Goodman, H. T.	Terre Haute	Vigo
Genovese, Pasquale	Indianapolis	Marion	Goodwin, Caroline J.	Indianapolis	Marion
Gentile, John P.	New Albany	Floyd	Goodwin, C. B. (S)	Kendallville	Noble
George, Charles L.	Indianapolis	Marion	Gootee, Francis H.	Loogootee	Daviess- Martin
Gerding, William J.	Fort Wayne	Allen	Gootee, Thomas H.	Jasper	Dubois
Geronimo, Manuel M.	Hammond	Lake	Goralka, Joseph J.	Chicago, Ill.	Lake
Geronimo, Rita R. V.	Hammond	Lake	Gordon, Joseph L.	Wheeler	Porter
Gerrish, D. A.	Terre Haute	Vigo	Gosman, James H.	Indianapolis	Marion
Gerrish, W. D. (S)	Clinton	Parke- Vermillion	Gossard, Meredith B.	Tipton	Vigo
Gery, Richard E.	Lafayette	Tippecanoe	Gossom, Donn R.	Terre Haute	Vigo
Getty, William H.	Evansville	Vanderburgh	Gould, L. K.	Ft. Wayne	Allen
Gevirtz, M. B.	Hammond	Lake	Govorchin, Alexander	East Chicago	Lake
Geyer, Joseph	Ashley	Steuben	Graessle, Harold P.	Seymour	Jackson
Gibbs, Charles (S)	Greenfield	Hancock	Graf, John E. (S)	Chicago, Ill.	Marion
Gibbs, Joseph W.	Martinsville	Morgan	Graf, John P.	South Bend	St. Joseph
Gibson, Greta	Indianapolis	Marion	Graf, Jerome A.	Bloomfield	Greene
Gick, Herman	Indianapolis	Marion	Graham, George M.	Ft. Wayne	Allen
Gifford, F. E.	Indianapolis	Marion	Grant, Albert J.	North Judson	Starke
Gilbert, Ivan	Terre Haute	Vigo	Grant, Benjamin F.	Gary	Lake
Gilkison, William L. (S)	Shoals	Daviess- Martin	Grant, John H.	Logansport	Cass
Gill, Bernard P.	Chandler	Warrick	Grant, M. Arthur	Fairmount	Grant
Gill, Dee Dar	Greenfield	Hancock	Graves, J. W.	Indianapolis	Marion
Gill, John R.	Hobart	Lake	Graves, Noel S.	Vevay	Jefferson- Switzerland
Gill, Thomas A.	Muncie	Delaware- Blackford	Graves, Orville M.	Princeton	Gibson
Gillespie, Chas. E. (S)	Seymour	Jackson	Gray, Clyde C.	Cloverdale	Putnam
Gillespie, Chas. F.	Indianapolis	Marion	Gray, D. E.	Crown Point	Lake
Gillespie, G. R.	Brownstown	Jackson	Gray, Leon	Martinsville	Morgan
Gillespie, J. E.	Indianapolis	Marion	Gray, Paul M.	Huntington	Huntington
Gillette, Edward P.	Indianapolis	Marion	Grayston, Wallace S. (S)	Huntington	Huntington
Gillette, Walter R.	Bluffton	Wells	Green, Carl L.	Vincennes	Knox
Gilliatt, J. P.	Salem	Washington	Green, F. H., Jr.	Rushville	Rush
Gillum, Eugene M.	Portland	Jay	Green, George F.	South Bend	St. Joseph
Gillum, John R. (S)	Terre Haute	Vigo	Green, John H.	North Vernon	Jennings
Gilman, M. M.	South Bend	St. Joseph	Green, Harrison	Indianapolis	Marion
Gilmore, Louis (S)	Vincennes	Knox	Green, Leonard J.	Valparaiso	Porter
Gilmore, R. A.	Michigan City	La Porte	Green, Norval E.	South Bend	St. Joseph
Gilmore, Robert W.	Michigan City	LaPorte	Green, Oscar	Indianapolis	Marion
Gingerick, Chas. M.	Liberty Center	Wells	Green, Wm. L. (S)	Pekin	Washington
Giordano, A. S.	South Bend	St. Joseph	Greenbank, Richard K.	Indianapolis	Marion
Girod, Arthur H.	Decatur	Adams	Greenburg, Rolland	Jasper	Dubois
Gish, Howard M.	Brookston	White	Greene, Claude D.	Spencer	Owen-Monroe
Gitlin, Max M.	Bluffton	Wells	Greene, Morgan E.	Indianapolis	Marion
Gitlin, Wm. A.	Bluffton	Wells	Greene, Wm. R.	Henryville	Clark
Givner, David	Indianapolis	Marion	Gregg, Albert F.	Connersville	Fayette- Franklin
Glackman, J. C., Jr.	Rockport	Spencer	Gregg, Edwin E.	Thorntown	Boone
Glackman, J. C., Sr.	Rochester	Fulton	Gregoline, A. F.	Gary	Lake
Gladstone, N. H.	Fort Wayne	Allen	Gregory, Charles F.	Corona, Calif.	Marion
Glass, R. L.	Indianapolis	Marion	Greiber, Marvin F.	Muncie	Delaware- Blackford
Glendening, J. L.	Indianapolis	Marion	Greip, Arthur H.	Evansville	Vanderburgh
Glendening, Richard L.	Spring- field, Ill.	Marion	Greisen, Jack G.	Whiting	Lake
Glenn, Fred C.	Tell City	Perry	Greist, H. W. (S)	Monticello	White
Glock, H. E. (S)	Fort Wayne	Allen	Greist, John	Indianapolis	Marion
Glock, M. E.	Ft. Wayne	Allen	Greist, Walter D.	Fort Wayne	Allen
Glock, Wayne R.	Ft. Wayne	Allen	Griffin, J. P.	Chesterton	Porter
Glosson, Jack R.	Clay City	Clay	Griffis, V. C.	Richmond	Wayne-Union
Gobbel, N. E.	English	Harrison- Crawford	Griffith, Harold	Indianapolis	Marion
Goebel, Carl W.	Fort Wayne	Allen	Griffith, James W.	Sheridan	Hamilton
Godersky, George E.	South Bend	St. Joseph	Griffith, R. E.	Indianapolis	Marion
Goethals, Charles J.	Mishawaka	St. Joseph	Griffith, Richard S.	Indianapolis	Marion
Goldberg, Harold B.	Gary	Lake	Grillo, Donald	South Bend	St. Joseph
Goldman, Samuel	Indianapolis	Marion	Grimes, Hubert	Indianapolis	Marion
			Gripe, R. P.	Lafayette	Tippecanoe
			Grisell, Ted L.	Indianapolis	Marion



Name	City	County	Name	City	County
Griswold, W. R.	Carlsbad, Calif.	Marion	Hanson, Martin F.	Elwood	Madison
Groman, Herman C.	Hammond	Lake	Harcourt, A. K.	Indianapolis	Marion
Grosso, W. G.	East Chicago	Lake	Harden, Murray E.	Lafayette	Tippecanoe
Grorud, Alton C.	South Bend	St. Joseph	Hardin, W. E.	Ossian	Wells
Grotts, Bruce F.	Michigan City	LaPorte	Harding, M. Richard	Indianapolis	Marion
Grove, Robert H.	Rossville	Clinton	Harding, Myron S.	Indianapolis	Marion
Gustafson, Carl J.	Marion	Grant	Hardtke, Eldred F.	Bloomington	Owen-Monroe
Gustafson, Milton	Muncie	Delaware-Blackford	Hardy, John J.	North Liberty	St. Joseph
Gustaitis, John W.	East Chicago	Lake	Hare, Daniel M.	Evansville	Vanderburgh
Gutelius, C. B. (S)	Indianapolis	Marion	Hare, E. H.	Indianapolis	Marion
Guthrie, F. C.	Vero Beach, Fla.	Madison	Hare, Francis W., Jr.	Madison	Jefferson-Switzerland
Guthrie, James U.	Nellis A.F.B., Nevada	Marion	Hare, Laura	Indianapolis	Marion
Gutstein, Richard R.	Kendallville	Noble	Harger, Robert W.	Indianapolis	Marion
Gwaltney, L. F.	Roachdale	Putnam	Harkcom, H. E.	St. Paul	Decatur
Gwin, Merle D. (S)	Miami Beach, Fla.	Jasper-Newton	Harkness, R. G.	Terre Haute	Vigo
	H		Harless, Clarence M.	Chesterton	Porter
Habich, Carl	Indianapolis	Marion	Harless, Fred	Monroeville	Allen
Hade, Frederick L.	Bridgeport	Marion	Harmon, C. J.	Richmond	Wayne-Union
Hadley, David	Indianapolis	Marion	Harmon, Vachelle E.	South Bend	St. Joseph
Hadley, Harvey (S)	Richmond	Wayne-Union	Harmon, Wayne	Lynn	Randolph
Hadley, Murray N. (S)	Indianapolis	Marion	Harold, A. H. (S)	Indianapolis	Marion
Haffner, H. G.	Ft. Wayne	Allen	Harold N. E. (S)	Indianapolis	Marion
Haggard, E. B.	Indianapolis	Marion	Harris, Carl B.	Indianapolis	Marion
Hahn, E. V.	Indianapolis	Marion	Harris, Howard H.	Terre Haute	Vigo
Haley, Paul E.	South Bend	St. Joseph	Harris, Jackson	Indianapolis	Marion
Halfast, Richard W.	Kokomo	Howard	Harris, Loftin	Evansville	Vanderburgh
Hall, Bernard R.	Logansport	Cass	Harris, Paul N.	Indianapolis	Marion
Hall, E. H.	Dunkirk	Jay	Harris, R. F.	Noblesville	Hamilton
Hall, Frank M.	Indianapolis	Marion	Harrison, B. L.	New Castle	Henry
Hall, Jack R.	Indianapolis	Marion	Harshman, L. P.	Ft. Wayne	Allen
Hall, James M.	South Bend	St. Joseph	Harshman, Martin L.	Lafayette	Tippecanoe
Hall, Orville A.	Muncie	Delaware-Blackford	Harstad, Casper	Rockville	Parke-Vermillion
Hall, Thomas C.	Chesterton	Porter	Hart, L. Paul	Evansville	Vanderburgh
Halleck, H. J.	Winamac	Pulaski	Hart, Robert B.	Columbus	Bartholomew-Brown
Haller, Robert L.	Fort Wayne	Allen	Hart, Wm. D.	Anderson	Madison
Haller, Thomas C.	Crawfordsville	Montgomery	Harter, Eli Blair	Lafayette	Tippecanoe
Hamer, Homer G.	Indianapolis	Marion	Hartley, C. A., Jr.	Evansville	Vanderburgh
Hamilton, Antha A.	Vevay	Jefferson-Switzerland	Hartman, John	Angola	Steuben
Hamilton, Charles O.	South Bend	St. Joseph	Hartsough, Ralph I.	Remington	Jasper-Newton
Hamilton, Earl D.	Fort Wayne	Allen	Hartz, F. Minton	Evansville	Vanderburgh
Hamilton, Emory D.	Ft. Wayne	Allen	Harvey, Harry C.	Ft. Wayne	Allen
Hamilton, Guy (S)	Durato, Calif.	Jefferson-Switzerland	Harvey, R. J.	Zionsville	Boone
Hamilton, J. R.	Mitchell	Lawrence	Harvey, Verne K.	Alexandria, Va.	Marion
Hamilton, M. Luther	Newberry	Greene	Hasewinkle, A. M.	Ft. Wayne	Allen
Hamilton, Orville G.	Bluffton	Wells	Hasewinkel, Carroll	Indianapolis	Marion
Hamilton, Robert C.	East Chicago	Lake	Hash, John S.	Noblesville	Hamilton
Hamilton, Thomas	Columbia City	Whitley	Haslem, Ezra R.	Terre Haute	Vigo
Hammel, Howard T.	Bedford	Lawrence	Haslem, John R.	Terre Haute	Vigo
Hammer, Jay Wm.	Middletown	Henry	Haslinger, C. J.	Indianapolis	Marion
Hammersley, Geo. K.	Frankfort	Clinton	Hastings, Warren C.	Ft. Wayne	Allen
Hammond, James B.	Indianapolis	Marion	Hatfield, B. F.	Indianapolis	Marion
Hammond, Keith	Paoli	Orange	Hatfield, Jack J.	Indianapolis	Marion
Hammond, R. Case	Evansville	Vanderburgh	Hatfield, Margaret	Indianapolis	Marion
Hammond, Stanley M.	Portland	Jay	Hatfield, N. W.	Indianapolis	Marion
Hampshire, Don R.	Indianapolis	Marion	Hathaway, Clayton B.	Butler	DeKalb
Hampton, Hollis E., Jr.	Indianapolis	Marion	Hattendorf, A. P.	Ft. Wayne	Allen
Hamsher, John B.	Terre Haute	Vigo	Haugseth, Ellsworth K.	South Bend	St. Joseph
Hancock, John G.	Indianapolis	Marion	Haus, Augustus P.	New Albany	Floyd
Hanley, Edward J.	Indianapolis	Marion	Havens, A. Lyle	Jeffersonville	Clark
Hann, Eldon C.	Indianapolis	Marion	Havens, Oscar	Cicero	Hamilton
Hanna, Duke E., Jr.	Indianapolis	Marion	Havens, R. E.	Ft. Wayne	Allen
Hanna, T. A.	Indianapolis	Marion	Havice, Jay F.	Lake Lure, N. C.	Allen
Hannah, Jack W.	Wakarusa	Elkhart	Hawes, J. K. (S)	Columbus	Bartholomew-Brown
Hansell, R. M.	Indianapolis	Marion	Hawes, M. E.	Columbus	Bartholomew-Brown
Hansen, A. H.	Hammond	Lake	Hawk, James H.	Indianapolis	Marion
			Hayes, Jess D.	East Chicago	Lake



Name	City	County	Name	City	County
Hayes, T. R.	Muncie	Delaware-Blackford	Higgins, John R.	New Albany	Floyd
Haymond, George N.	Warsaw	Kosciusko	High, Ralph L.	Muncie	Delaware-Blackford
Haymond, Joseph L.	Indianapolis	Marion	Hilbert, John W.	South Bend	St. Joseph
Hays, Everett L.	Indianapolis	Marion	Hildebrand, John O., Jr.	South Bend	St. Joseph
Hays, George R. (S)	Richmond	Wayne-Union	Hildebrand, W. O. (S)	Topeka	LaGrange
Hayter, Robert	Lyons	Greene	Hill, Gladys Marie	Richmond	Wayne-Union
Hazinski, R. T.	Griffith	Lake	Hill, H. D.	Richmond	Wayne-Union
Headley, L. M.	Lebanon	Boone	Hill, H. E.	Muncie	Delaware-Blackford
Heard, Albert	Evansville	Vanderburgh	Hill, Kenneth G.	New Castle	Henry
Heck, Martin C.	Jasper	Dubois	Hill, Lloyd	Indianapolis	Marion
Heck, Rolfe A.	College Corner, Ohio	Wayne-Union	Hill, Paul G.	Cambridge City	Wayne-Union
Hedde, E. L.	Logansport	Cass	Hill, Robert	Muncie	Delaware-Blackford
Hedgcock, R. A.	Frankfort	Clinton	Hill, T. N.	Scottsburg	Scott
Hedrick, James T.	Gary	Lake	Hill, Theodore A.	South Bend	St. Joseph
Hedrick, Philip W.	Indianapolis	Marion	Hilddrup, Don G.	Indianapolis	Marion
Heilman, W. C.	New Castle	Henry	Hillenbrand, Charles	Michigan City	LaPorte
Heinrich, Weston A.	Evansville	Vanderburgh	Hillery, John L.	Warsaw	Kosciusko
Heinrichs, Harry H.	Indianapolis	Marion	Hillis, L. J.	Logansport	Cass
Held, George A.	Jasper	Dubois	Hillman, Marion W.	South Bend	St. Joseph
Heller, N. L.	Dunkirk	Jay	Hillman, W. H. (S)	South Bend	St. Joseph
Helmen, H. W.	South Bend	St. Joseph	Himebaugh, Gilbert	Rochester, Minn.	Fountain-Warren
Helmer, John F.	South Bend	St. Joseph	Himebaugh, J. R. S.	Indianapolis	Marion
Hendershot, Eugene L.	Evansville	Vanderburgh	Himler, James M.	Indianapolis	Marion
Henderson, Arvin	Ridgeville	Randolph	Hinchman, C. P.	Geneva	Adams
Henderson, Francis G.	Indianapolis	Marion	Hinchman, Jean F.	Parker	Randolph
Henderson, N. C.	Michigan City	LaPorte	Hine, U. B.	Indianapolis	Marion
Henderson, R. A.	Muncie	Delaware-Blackford	Hines, A. V.	Auburn	DeKalb
Henderson, Roscoe C.	Indianapolis	Marion	Hines, Don C.	Indianapolis	Marion
Hendricks, John D. (S)	Indianapolis	Marion	Hippensteel, Harland	Auburn	DeKalb
Hendricks, John W.	Indianapolis	Marion	Hippensteele, Ralph	Fremont	Steuben
Hendrix, Claude	Waveland	Montgomery	Hirsch, Herman L.	Mt. Vernon	Posey
Henn, R. Anthony	Greenfield	Hancock	Hisrich, L. W.	Batesville	Ripley
Henning, Carl (S)	Hanover	Jefferson-Switzerland	Hobbs, Arthur	Evansville	Vanderburgh
Henry, Alvin L.	Columbus	Bartholomew-Brown	Hochhalter, Marian	Logansport	Cass
Henry, Howard J.	Knox	Starke	Hodges, Fletcher (S)	Indianapolis	Marion
Henry, Russell S.	Indianapolis	Marion	Hodges, Wm. A.	Oaktown	Knox
Hensler, B. M.	Anderson	Madison	Hodgin, Phillip	Orleans	Orange
Hepburn, C. K.	Indianapolis	Marion	Hodurski, Zigfield	Gary	Lake
Hepner, Herman	Kendallville	Noble	Hoffman, A. F.	Ft. Wayne	Allen
Hepner, H. S.	Bloomington	Owen-Monroe	Hoffman, Doris	Vincennes	Knox
Herd, Cloyd R.	Peru	Miami	Hoffman, Herman	Indianapolis	Marion
Herendeen, E. V.	Rochester	Fulton	Hoffman, R. V.	South Bend	St. Joseph
Heritier, C. Jules	Columbia City	Whitley	Hoffmann, S. P., Sr.	Ft. Wayne	Allen
Hermayer, Stephen	Evansville	Vanderburgh	Hofmann, Andrew (S)	Hammond	Lake
Herr, John W.	Mt. Vernon	Posey	Hofmann, J. Wm.	Indianapolis	Marion
Herrick, C. L.	Akron	Fulton	Hogle, Frank D.	Logansport	Cass
Herring, G. N.	Richmond	Wayne-Union	Holdeman, Lillian	South Bend	St. Joseph
Herrmann, Gordon T.	Evansville	Vanderburgh	Holdeman, R. W.	South Bend	St. Joseph
Herrold, G. W.	Lafayette	Tippecanoe	Holladay, L. J.	Lafayette	Tippecanoe
Hershberger, Philip	Indianapolis	Marion	Holland, Chas. E.	Goodland	Jasper-Newton
Hershey, E. A.	Churubusco	Whitley	Holland, D. J. (S)	Bloomington	Owen-Monroe
Herzberg, Milton	Clinton	Parke-Vermillion	Holland, Philip	Bloomington	Owen-Monroe
Herzer, C. C.	Evansville	Vanderburgh	Hollingsworth, A. A. (S)	Indianapolis	Marion
Hess, Paul P.	New Albany	Floyd	Hollingsworth, Marshall P. (S)	Princeton	Gibson
Hetherington, A. M.	Indianapolis	Marion	Hollis, Walter H.	Ft. Branch	Gibson
Hetherington, John A.	Indianapolis	Marion	Holloway, W. A. (S)	Logansport	Cass
Hetman, Mitchell J.	Westville	LaPorte	Holman, J. E., Sr.	Indianapolis	Marion
Heubi, John E.	Indianapolis	Marion	Holman, J. E., Jr.	Indianapolis	Marion
Hiatt, R. L.	Ft. Wayne	Allen	Holmes, Claude D., Sr.	Frankfort	Clinton
Hibner, Nolan A.	Monticello	White	Holmes, G. W.	Gary	Lake
Hickman, A. Lee	Hammond	Lake	Holmes, John L.	Indianapolis	Marion
Hickman, Walter	Indianapolis	Marion	Holsinger, R. E.	Indianapolis	Marion
Hicks, Joseph (S)	Arcadia	Hamilton	Holtzman, Norman H.	South Bend	St. Joseph
Hicks, Murwyn L.	Indianapolis	Marion	Honan, Paul R.	Lebanon	Boone
Hiestand, H. J.	Pennville	Jay	Hood, Ainslee A.	Indianapolis	Marion
Higbee, Paul	Sullivan	Sullivan			
Higgins, James L.	Petersburg	Pike			

Name	City	County
Hooke, Sam W.	Noblesville	Hamilton
Hooley, Paul E.	Indianapolis	Marion
Hoopes, Jane	Evansville	Vanderburgh
Hoover, Ammon W.	Michigan City	LaPorte
Hoover, D. A.	Terre Haute	Vigo
Hoover, Peter B.	Boonville	Warrick
Hopkins, J. R.	Hammond	Lake
Hopkins, Lester H.	Versailles	Ripley
Hoppenrath, Wesley M.	Elwood	Madison
Hoppenrath, Wm. (S)	Elwood	Madison
Horst, William N.	Crown Point	Lake
Horswell, R. G.	Bristol	Elkhart
Horwitz, Thomas	Indianapolis	Marion
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware-Blackford

Houser, D. Stanley	Lakeville	St. Joseph
Houser, Wayne W.	Monon	White
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio

How, John T. (S)	Lakeville	St. Joseph
How, Louis E.	South Bend	St. Joseph
Howard, W. H.	Hammond	Lake
Howe, Fordyce L.	Ft. Wayne	Allen
Howell, Joseph D.	Indianapolis	Marion
Howell, R. D.	Indianapolis	Marion
Hoyt, John M.	Westville	LaPorte
Hoyt, Lester H.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Carl D.	Indianapolis	Marion
Huckleberry, Irvin	Salem	Washington
Huddle, John R.	Indianapolis	Marion
Hudson, Arlington M.	Connersville	Fayette-Franklin

Hudson, Foster J.	Indianapolis	Marion
Huffman, A. D.	Acton	Marion
Huffman, V. P.	South Whitley	Whitley
Hughes, Richard R.	Lafayette	Tippecanoe
Hughes, W. F. (S)	Indianapolis	Marion
Huggins, Victor S.	Evansville	Vanderburgh
Hull, A. W.	Elkhart	Elkhart
Hull, James E.	Boston, Mass.	Marion
Hull, Ronald H.	Indianapolis	Marion
Hummel, R. M.	Marion	Grant
Hummel, Paul	Lafayette	Tippecanoe
Hummons, Francis D.	Indianapolis	Marion
Hummons, Henry L.	Indianapolis	Marion
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John W.	Crawfordsville	Montgomery
Hunsberger, W. G.	Lafayette	Tippecanoe
Hungerford, Louis N.	Indianapolis	Marion
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union

Hunter, Donn	Greenfield	Hancock
Hunter, F. P.	Lafayette	Tippecanoe
Hunter, Lowell G.	Milan	Ripley
Huoni, J. S.	Jeffersonville	Clark
Hurley, Anson	Muncie	Delaware-Blackford

Hurley, John R.	Daleville	Delaware-Blackford
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Hurt, L. B.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert	Hammond	Lake
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, W. H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll	South Bend	St. Joseph
Hynes, Roy T.	Indianapolis	Marion

## I

Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert	Shelbyville	Shelby

Name	City	County
Inlow, W. D.	Shelbyville	Shelby
Irish, Wilbur J.	East Chicago	Lake
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth	Anderson	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, N. C.	Jeffersonville	Clark
Iterman, G. E.	New Castle	Henry
Ives, R. J.	Francesville	Pulaski
Ivy, John H.	Elkhart	Elkhart

## J

Jackson, Charles E.	Bluffton	Wells
Jackson, Dean B.	Hartford City	Delaware-Blackford

Jackson, F. E.	Indianapolis	Marion
Jackson, James W.	Indianapolis	Marion
Jackson, Jesse L.	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, J. K.	Aurora	Dearborn-Ohio

Jaeger, A. S. (S)	Indianapolis	Marion
Jahns, Albin A.	Gary	Lake
James, John M.	Tell City	Perry
James, N. A.	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jannasch, Maurice C.	Gary	Lake
Jaquith, O. S. (S)	Indianapolis	Marion
Jarrett, John C.	Marion	Grant
Jarrett, Paul E.	Fairchild, Wash.	Madison

Jay, Arthur N.	Indianapolis	Marion
Jean, Thomas A.	Morristown	Shelby
Jeans, Robert F.	Dyer	Lake
Jeffries, K. I. (S)	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jennings, F. Lamont	Chicago, Ill.	Marion
Jennings, Frank	Indianapolis	Marion
Jewell, Earl B.	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jewett, Laurence (S)	Excelsior Springs, Mo.	Wabash

Jewett, Robert E.	Kansas City, Mo.	Marion
Jinks, C. H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	DeKalb
Jobs, James E.	Indianapolis	Marion
Jobs, N. E. (S)	Indianapolis	Marion
Joest, Charles O.	South Bend	St. Joseph
Johns, D. R.	East Chicago	Lake
Johns, N. C.	South Bend	St. Joseph
Johnson, C. E.	Rensselaer	Jasper-Newton

Johnson, F. D.	Waynetown	Montgomery
Johnson, G. C. (S)	Evansville	Vanderburgh
Johnson, George M.	Richmond	Wayne-Union
Johnson, Herbert S.	Lafayette	Tippecanoe
Johnson, James B.	Greencastle	Putnam
Johnson, J. M.	Palmyra	Harrison-Crawford

Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, Owen	Peru	Miami
Johnson, Paul S. (S)	Richmond	Wayne-Union
Johnson, R. B.	Rushville	Rush
Johnson, S. L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, W. A.	Perrysville	Parke-Vermillion

Johnson, William A.	North Vernon	Jennings
Johnson, Wm. F.	Indianapolis	Marion
Johnston, Alan	Plainfield	Hendricks
Johnston, Richard M.	Fort Wayne	Allen



Name	City	County	Name	City	County
Johnston, Robert L.	Bluffton	Wells	Kelly, Walter F. (S)	Indianapolis	Marion
Johnston, R. G.	Huntington	Huntington	Kelly, William M.	Indianapolis	Marion
Jolly, Lewis E.	Madison	Jefferson-Switzerland	Kelsey, L. E.	Kewanna	Fulton
Jones, Albert T.	Anderson	Madison	Kelsey, Robert M.	LaPorte	La Porte
Jones, Allen W.	Indianapolis	Marion	Kemp, John T.	Michigan City	La Porte
Jones, Charles A.	Franklin	Johnson	Kemp, W. A.	Connersville	Fayette-Franklin
Jones, Clifford M.	Whiting	Lake	Kemper, A. T. (S)	Muncie	Delaware-Blackford
Jones, David	Lafayette	Tippecanoe	Kempf, G. F.	Indianapolis	Marion
Jones, David E.	Indianapolis	Marion	Kerdall, F. M.	Nappanee	Elkhart
Jones, E. S.	Hammond	Lake	Kendrick, Frank J.	Gary	Lake
Jones, Francis P.	Indianapolis	Marion	Kendrick, W. M.	Indianapolis	Marion
Jones, George	Wanamaker	Marion	Kennedy, Eva	Camden	Carroll
Jones, H. E.	Anderson	Madison	Kennedy, Hall	Indianapolis	Marion
Jones, John C.	LaPorte	LaPorte	Kennedy, H. F.	Indianapolis	Marion
Jones, John Carl	Logansport	Cass	Kennedy, R. O. (S)	Rushville	Rush
Jones, King Solomon	Michigan City	LaPorte	Kennedy, W. U.	New Castle	Henry
Jones, R. B.	LaPorte	LaPorte	Kenney, Francis D.	Hammond	Lake
Jones, Roland W.	Indianapolis	Marion	Kent, Richard N.	Ft. Wayne	Allen
Jones, W. W.	Frankfort	Clinton	Kenyon, C. E.	Cambridge City	Wayne-Union
Jordan, Leo E.	Lynn	Randolph	Kenyon, Omar A.	Indianapolis	Marion
Joseph, Rex M.	Indianapolis	Marion	Kephart, S. Bruce	Bluffton	Wells
Jurgensen, Walter T.	Ft. Wayne	Allen	Kepler, R. W.	La Porte	La Porte
Justen, Jerome W.	Ft. Monroe, Va.	Lake	Kercheval, John M.	Clinton	Parke-Vermillion
K			Kern, C. B. (S)	Muncie	Delaware-Blackford
Kabel, Robert N.	Terre Haute	Vigo	Kern, C. G.	Lebanon	Boone
Kahan, H. L.	Tucson, Ariz.	Lake	Kerr, Donald M.	Bedford	Lawrence
Kahle, Dan B.	Indianapolis	Marion	Kerr, Harry R.	Indianapolis	Marion
Kahler, M. V.	Indianapolis	Marion	Kerrigan, John F.	Michigan City	LaPorte
Kahn, Alexander J.	Indianapolis	Marion	Kerrigan, R. L.	Michigan City	La Porte
Kahn, Howard L.	Indianapolis	Marion	Kerrigan, William F.	Connersville	Fayette-Franklin
Kalb, Everett L.	Indianapolis	Marion	Keseric, Nicholas E.	French Lick	Orange
Kamen, Jack M.	East Chicago	Lake	Kessler, Robert B.	Evansville	Vanderburgh
Kamm, Bernard A.	South Bend	St. Joseph	Ketcham, Jane M.	Indianapolis	Marion
Kamman, G. H. (S)	Seymour	Jackson	Ketcham, John S.	Rossville	Clinton
Kammen, Leo	Indianapolis	Marion	Keyes, Robert C.	Indianapolis	Marion
Kammen, Robert	Indianapolis	Marion	Keys, Lynn	Evansville	Vanderburgh
Kammer, Grace C.	Muncie	Delaware-Blackford	Khaton, Odessa M.	Gary	Lake
Kammer, Walter F.	Muncie	Delaware-Blackford	Kidd, James G.	Roann	Wabash
Kantzer, Floyd B.	Garrett	De Kalb	Kidder, Orva T.	Ft. Wayne	Allen
Kaplan, Benjamin B.	Hammond	Lake	Kilgore, Byron, Jr.	Indianapolis	Marion
Karberg, Richard J.	Lafayette	Tippecanoe	Killian, E. Camille	Logansport	Cass
Karn, John W.	South Bend	St. Joseph	Kilmer, Warren L.	Gary	Lake
Karns, John D.	Winamac	Pulaski	Kim, Young D.	Beech Grove	Marion
Karol, Herbert J.	Fort Wayne	Allen	Kimbrough, Robert F.	Fort Wayne	Allen
Karpel, Bernard	Mooresville	Morgan	Kime, Charles E.	Richmond	Wayne-Union
Karsell, W. A.	Bloomington	Owen-Monroe	Kime, E. N.	Indianapolis	Marion
Katterjohn, James C.	Indianapolis	Marion	Kime, J. T. (S)	Petersburg	Pike
Kauffman, Harley M.	Evansville	Vanderburgh	Kincaid, Raymond K.	Tipton	Tipton
Kauffman, Nelson N.	Indianapolis	Marion	Kindell, H. D.	New Richmond	Montgomery
Kauffman, Sidney A.	Indianapolis	Marion	King, Dale	Fairmount	Grant
Kaufman, Julian	Fort Wayne	Allen	King, Joseph W.	Anderson	Madison
Kay, Oran	Spencer	Owen-Monroe	King, P. C.	Swayzee	Grant
Keck, Carleton A.	Fort Wayne	Allen	King, Robert W.	Cedar Lake	Lake
Keeling, F. E.	Portland	Jay	King, William B.	Cedar Lake	Lake
Keeling, J. E. (S)	Waldron	Shelby	King, William E.	Indianapolis	Marion
Keenan, George B.	Indianapolis	Marion	King, William F. (S)	Indianapolis	Marion
Keenan, R. L.	Indianapolis	Marion	Kingsbury, J. K.	Indianapolis	Marion
Keever, C. H.	Indianapolis	Marion	Kinnaman, H. A.	Crawfordsville	Montgomery
Keezer, William S.	Vincennes	Knox	Kinneman, R. E.	Greenfield	Hancock
Keiser, V. D.	Indianapolis	Marion	Kintner, Burton E.	Elkhart	Elkhart
Keith, F. E. (S)	St. Bernice	Parke-Vermillion	Kinzel, Robert J. W.	Indianapolis	Marion
Keller, Foster C.	Fort Wayne	Allen	Kinzie, M. Dale	Indianapolis	Marion
Keller, Frank (S)	Alexandria	Madison	Kirby, Ted C.	Greenfield	Hancock
Kelly, Don E.	Indianapolis	Marion	Kirkhoff, Paul J.	Indianapolis	Marion
Kelly, Frank	Argos	Marshall	Kirklin, Oren L.	Indianapolis	Marion
Kelly, J. F.	Indianapolis	Marion	Kirshman, F. E.	Muncie	Delaware-Blackford
Kelly, W. C.	Anderson	Madison	Kirtley, J. M.	Crawfordsville	Montgomery
Kelly, W. R.	Goshen	Elkhart	Kirtley, William R.	Indianapolis	Marion
			Kiser, E. F.	Indianapolis	Marion



Name	City	County	Name	City	County
Kissinger, K. L.	Angola	Steuben	Kuhn, Hedwig S.	Hammond	Lake
Kistler, James J.	La Porte	La Porte	Kuhn, Hugh A.	Hammond	Lake
Kistner, Arthur W.	Elkhart	Elkhart	Kuhn, R. W.	Wilkinson	Hancock
Kitterman, Harry E.	Indianapolis	Marion	Kunkler, Joseph	Terre Haute	Vigo
Klahr, Elsworth	South Bend	St. Joseph	Kunkler, Wm. C.	Terre Haute	Vigo
Klain, B. V.	Indianapolis	Marion	Kuntz, Herman W.	Indianapolis	Marion
Klamer, Charles H.	Jasper	Dubois	Kurtz, Fred B. (S)	Indianapolis	Marion
Klatch, Ben Z.	Lafayette	Tippecanoe	Kurtz, Philip L.	Indianapolis	Marion
Klaus, J. M.	Hobart	Lake	Kurtz, William A.	Tipton	Tipton
Kleifgen, William A.	Fort Wayne	Allen	Kwitny, I. J.	Indianapolis	Marion
Kleindorfer, R. L.	Evansville	Vanderburgh			
Kleinman, F. J.	Hebron	Porter	L		
Klepfer, Jefferson	Richmond	Wayne-Union	LaBier, C. Russell	Terre Haute	Vigo
Klepinger, H. E.	Lafayette	Tippecanoe	LaBier, Clarence R. (S)	Terre Haute	Vigo
Kling, Victor F.	Michigan City	La Porte	Ladig, Donald S.	Fort Wayne	Allen
Klingler, Maurice O.	Plymouth	Marshall	LaDine, C. B.	Indianapolis	Marion
Knapp, Arthur L. (S)	South Bend	St. Joseph	LaDuron, Jules F.	Muncie	Delaware- Blackford
Kneidel, John H.	Frankfort	Clinton			
Knepple, L. R. (S)	Kokomo	Howard	LaFollette, Don	New Albany	Floyd
Knight, Robert E.	Indianapolis	Marion	LaFollette, Forrest R.	Whiting	Lake
Knode, Kenneth T.	South Bend	St. Joseph	LaFollette, Robert E.	New Albany	Floyd
Knotts, Slater	Rochester	Fulton	Laird, L. A.	Richmond	Wayne-Union
Knowles, Charles Y.	Indianapolis	Marion	Lamb, E. B.	Indianapolis	Marion
Knowles, Robert P.	Indianapolis	Marion	Lamb, J. Leonard	South Bend	St. Joseph
Knox, Edwin S.	Indianapolis	Marion	Lamb, Russell	Indianapolis	Marion
Ko, Richard	Eaton	Delaware- Blackford	Lamber, C. K.	Indianapolis	Marion
			Lamey, James L.	Anderson	Madison
Kobrak, H. G.	Chicago, Ill.	Lake	Lamey, P. T.	Anderson	Madison
Kobrin, Meyer W.	Gary	Lake	Lancet, Robert O.	Terre Haute	Vigo
Koch, Elmer L.	Danville	Hendricks	Land, Francis L.	Fort Wayne	Allen
Koch, Howard W.	Winchester	Randolph	Landis, Charles	Chicago, Ill.	Cass
Koehler, Elmer G.	Elkhart	Elkhart	Lane, W. H. (S)	Angola	Steuben
Kohlstaedt, George	Indianapolis	Marion	Lane, Wm. H.	South Bend	St. Joseph
Kohlstaedt, Karl C.	Indianapolis	Marion	Lang, Joseph E.	South Bend	St. Joseph
Kohlstaedt, K. G.	Indianapolis	Marion	Langdon, H. K. (S)	Indianapolis	Marion
Kohne, C. J.	Decatur	Adams	Langdon, J. Ray	San Antonio, Texas	Marion
Kohne, Robert W.	Indianapolis	Marion			
Kohrman, Benj. M.	Michigan City	La Porte	Langenbahn, C. J.	South Bend	St. Joseph
Kolanko, Leon A.	Hammond	Lake	Langohr, John	Columbia City	Whitley
Kolettis, George J.	Gary	Lake	Langsdon, Fred	Gaston	Delaware- Blackford
Komoroske, J. E.	East Chicago	Lake			
Koons, Karl M.	Indianapolis	Marion	Lanning, R. Adrian	Phoenix, Ariz.	Marion
Koontz, William A.	Gas City	Grant	Lansford, John	Redkey	Jay
Kopanko, Bernard F.	Huntington, W. Va.	Lake	Laramore, Ward	Indianapolis	Marion
			Larkin, Bernard J.	Indianapolis	Marion
Kopcha, Joseph E.	Gary	Lake	Larmore, J. L.	Anderson	Madison
Kopecky, Robert R.	Indianapolis	Marion	Larmore, Sarah H.	Anderson	Madison
Kopp, O. A.	Anderson	Madison	LaRocca, Joseph	South Bend	St. Joseph
Koransky, David S.	Hammond	Lake	Larrabee, James F.	Hammond	Lake
Korn, Jerome M.	Gary	Lake	Larrabee, Wm. H. (S)	New Palestine	Hancock
Kornafel, L. H.	Indianapolis	Marion	Larrison, G. D.	Morocco	Jasper- Newton
Kraft, Bennett	Indianapolis	Marion			
Kraft, Haldon C.	Noblesville	Hamilton	Larson, G. O.	La Porte	La Porte
Kramer, A. A. (S)	South Bend	St. Joseph	Larson, John A.	Logansport	Cass
Kranning, Kenneth	Kewanna	Fulton	LaSalle, R. M.	Wabash	Wabash
Kratz, Paul E.	Columbia City	Whitley	Lashley, Donald L.	Tell City	Perry
Kresler, Leon	Rensselaer	Jasper- Newton	Laubscher, Clarence	Evansville	Vanderburgh
			Laudeman, W. A.	Elwood	Madison
Kretsch, R. W.	Hammond	Lake	Lauer, D. B.	Dana	Parke- Vermillion
Kriebble, Wm. W.	Terre Haute	Vigo			
Krieger, George M.	Michigan City	La Porte	Lautz, Herbert A.	Hammond	Lake
Kriel, William B.	Indianapolis	Marion	Lavengood, R. W.	Marion	Grant
Kring, Gerald G.	LaPorte	LaPorte	Lawler, George F.	Indianapolis	Marion
Kron, R. Vincent	East Gary	Lake	Lawrence, Edwin A.	Indianapolis	Marion
Krueger, Frederick W. (S)	Richmond	Wayne-Union	Lawrence, Joseph C.	Evansville	Vanderburgh
			Laws, H. J.	Lafayette	Tippecanoe
Krueger, John E.	South Bend	St. Joseph	Laws, Kenneth F.	Lafayette	Tippecanoe
Krueger, Robert B.	Columbus	Bartholomew- Brown	Lawson, I. H.	Kendallville	Noble
			Lazo, Vicente R.	Hammond	Lake
Kruse, E. H.	Fort Wayne	Allen	Leak, Robert H.	Boswell	Benton
Kruse, Walter E.	Fort Wayne	Allen	Leasure, J. K.	Indianapolis	Marion
Kubik, Francis J.	Michigan City	La Porte	Leasure, Kenneth	Elkhart	Elkhart
Kublej, James D.	Plymouth	Marshall	Leatherman, H. L.	Indianapolis	Marion
Kudele, L. T.	Whiting	Lake	Lebioda, Henry S.	Gary	Lake
Kuder, Howard V.	Muncie	Delaware- Blackford	Lee, Glen Ward	Richmond	Wayne-Union
			Leedy, Gladys J.	Indianapolis	Marion
Kuhn, Frederick L.	South Bend	St. Joseph	Leff, Abe	Indianapolis	Marion





Name	City	County	Name	City	County
Manion, Marlow W.	Indianapolis	Marion	May, R. Milton.	Gary	Lake
Mankin, William J.	Terre Haute	Vigo	Mayfield, C. H. (S)	Reynolds	White
Manley, Chas. N.	Rising Sun	Dearborn- Ohio	McAdams, Hugh B.	Lafayette	Tippecanoe
Mann, Mortimer	Indianapolis	Marion	McAdams, Robert	Lafayette	Tippecanoe
Manning, George	Fort Wayne	Allen	McArdle, Edward G.	Ft. Wayne	Allen
Manning, K. R.	Indianapolis	Marion	McArt, Bruce A.	Elkhart	Elkhart
Manzie, Michael	Indianapolis	Marion	McAttee, Otto B.	Madison	Jefferson- Switzerland
Maple, J. B. (S)	Sullivan	Sullivan	McBride, James S.	Indianapolis	Marion
Marchand, Austin F.	Haubstadt	Gibson	McBride, Noel S.	Terre Haute	Vigo
Marchand, Edwin V.	Haubstadt	Gibson	McCabe, James E. (S)	Otterbein	Benton
Marchant, Clarence H.	Bloomington	Owen-Monroe	McCallister, John W.	Ft. Wayne	Allen
Marcus, Emanuel	Hammond	Lake	McCallum, J. T. C.	Indianapolis	Marion
Marcus, M. C.	Gary	Lake	McCarthy, Daniel J. (S)	Marion	Grant
Maris, Lee J.	Attica	Fountain- Warren	McCarthy, Jeremiah A.	Whiting	Lake
Markel, I. J.	Elkhart	Elkhart	McCartney, Donald H.	Indianapolis	Marion
Markey, R. J. P.	Hammond	Lake	McCarty, Virgil	Princeton	Gibson
Markle, Joseph G.	Hammond	Lake	McCaskey, C. H. (S)	Indianapolis	Marion
Marks, H. H.	Huntington	Huntington	McClain Edwin S.	Indianapolis	Marion
Marks, Maurice I.	Indianapolis	Marion	McClain, Marvin	Scottsburg	Scott
Marks, Ora L.	East Chicago	Lake	McClellan, John B.	Muncie	Delaware- Blackford
Marks, Salvo P.	Hammond	Lake	McClelland, D. C.	Lafayette	Tippecanoe
Marr, Griffith	Columbus	Bartholomew- Brown	McClelland, Harry N.	Alexandria	Madison
Marsh, Carl M.	Indianapolis	Marion	McClintock, James A.	Muncie	Delaware- Blackford
Marsh, Chester A.	Hagerstown	Henry	McClure, Clark	Knox	Starke
Marsh, George W.	Lafayette	Tippecanoe	McClure, S. E.	Monon	White
Marsh, William L.	Lafayette	Tippecanoe	McClure, Stanley M.	Kokomo	Howard
Marshall, Albert L., Jr.	Indianapolis	Marion	McConnell, Wm. C.	Sunman	Ripley
Marshall, C. L.	Fort Wayne	Allen	McCool, J. H.	Evansville	Vanderburgh
Marshall, C. R.	Indianapolis	Marion	McCord, C. B.	Veedersburg	Fountain- Warren
Marshall, George L.	Bourbon	Marshall	McCormick, C. O., Jr.	Indianapolis	Marion
Marshall, Lloyd C.	Mt. Summit	Henry	McCormick, C. O., Sr.	Indianapolis	Marion
Marshall, Millard R.	Gary	Lake	McCormick, H. D.	Vincennes	Knox
Martin, C. E.	Lynn	Randolph	McCormick, W. C.	Terre Haute	Vigo
Martin, Charles F.	Mishawaka	St. Joseph	McCown, P. E.	Indianapolis	Marion
Martin, Floyd S.	Goshen	Elkhart	McCoy, George E.	Muncie	Delaware- Blackford
Martin, Guy	Seymour	Jackson	McCoy, Melvin H.	Indianapolis	Marion
Martin, Harold G.	Mt. Clemens, Mich.	Tippecanoe	McCoy, Roy R.	Ft. Wayne	Allen
Martin, Hugh E.	Indianapolis	Marion	McCracken, J. O. (S)	Montgomery	Daviess- Martin
Martin, Loren H.	Indianapolis	Marion	McCraley, William J.	South Bend	St. Joseph
Martin, W. B.	La Porte	La Porte	McCrea, Fred R.	Terre Haute	Vigo
Martz, Bill L.	Indianapolis	Marion	McCullough, Henry G.	Columbus	Bartholomew- Brown
Martz, Carl D.	Indianapolis	Marion	McCullough, J. Y.	New Albany	Floyd
Marvel, Robert J.	Indianapolis	Marion	McDaniel, F. P.	Atlanta	Hamilton
Maschmeyer, R. H.	Logansport	Cass	McDevitt, D. R.	Indianapolis	Marion
Mason, Bernard	South Bend	St. Joseph	McDonald, Frank C.	New Castle	Henry
Mason, Donald G.	Angola	Steuben	McDonald, J. D.	Evansville	Vanderburgh
Mason, Everett E.	Evansville	Vanderburgh	McDonald, R. M.	South Bend	St. Joseph
Mason, Lester M.	Terre Haute	Vigo	McDonald, V. G.	Anderson	Madison
Mason, Naiad	Bloomington	Owen- Monroe	McDowell, Fletcher W.	Muncie	Delaware- Blackford
Mason, Richard L.	Hammond	Lake	McDowell, George A.	Ft. Wayne	Allen
Massanari, Walter	Millersburg	Elkhart	McDowell, M. M.	Vincennes	Knox
Masters, John M.	Indianapolis	Marion	McEachern, Cecil	Ft. Wayne	Allen
Masters, R. J.	Indianapolis	Marion	McElroy, J. S.	New Castle	Henry
Mather, Robert	Indianapolis	Marion	McElroy, R. S.	Princeton	Gibson
Mather, J. W.	East Gary	Lake	McEwen, J. W.	Terre Haute	Vigo
Mathys, Alfred	Mauckport	Harrison- Crawford	McFadden, James M.	Lafayette	Tippecanoe
Matteucci, Walter V.	Wabash	Wabash	McFall, J. R. S.	Ft. Wayne	Allen
Matthew, John R.	North Judson	Starke	McFarland, Corley B.	South Bend	St. Joseph
Matthew, W. B.	Indianapolis	Marion	McGilvray, Eva R. T.	Rockville	Parke- Vermillion
Matthews, B. J.	Indianapolis	Marion	McGrath, Michael F.	Indianapolis	Marion
Matthews, Chas. B. (S)	Hammond	Lake	McGue, Frank T.	Hobart	Lake
Matthews, D. W.	North Vernon	Jennings	McGuff, Paul	Indianapolis	Marion
Matthews, William M.	Indianapolis	Marion	McGuire, D. F.	East Chicago	Lake
Mattmiller, Everette D.	Avilla	Noble	McIlwain, Eleanor	Marion	Grant
Mattox, Don M.	Terre Haute	Vigo	McIlwain, Robert	Marion	Grant
Maurer, J. F.	Brazil	Clay	McIndoo, R. E.	Kokomo	Howard
Maurer, Robert M.	Brazil	Clay	McIntire, Clarence R.	Indianapolis	Marion
Maxson, Roy V.	Anderson	Madison			
Maxwell, J. B. (S)	Logansport	Cass			
May, George A.	Madison	Jefferson- Switzerland			



Name	City	County	Name	City	County
McIntosh, Wilbert	Riley	Vigo	Meyn, Werner P.	Terre Haute	Vigo
McIntyre, Charles J. (S)	Indianapolis	Marion	Michaelis, S. C.	Ft. Wayne	Allen
McIntyre, J. M.	Indianapolis	Marion	Michaels, Joseph F. (S)	Edinburg	Johnson
McKay, Robert	LaFontaine	Wabash	Middleton, H. N.	Indianapolis	Marion
McKee, Harry G.	Rushville	Rush	Middleton, Thomas O.	Bloomington	Owen-Monroe
McKee, Horace N. (S)	Elkhart	Elkhart	Mikesch, W. H. (S)	South Bend	St. Joseph
McKeeman, D. H.	Ft. Wayne	Allen	Miklozek, John E.	Terre Haute	Vigo
McKeeman, L. S.	Ft. Wayne	Allen	Miley, Weir M.	Anderson	Madison
McKenna, H. J.	South Bend	St. Joseph	Miller, Carl G.	Ft. Wayne	Allen
McKinley, A. D.	Indianapolis	Marion	Miller, Charles A. (S)	Princeton	Gibson
McKinley, Joseph	Lafayette	Tippecanoe	Miller, D. B. (S)	Terre Haute	Vigo
McKinney, D. H.	Lafayette	Tippecanoe	Miller, Dan T.	Fowler	Benton
McKinstry, Homer	Indianapolis	Marion	Miller, E. H.	Valparaiso	Porter
McKittrick, Jack	Washington	Daviess- Martin	Miller, Frank	Morristown	Shelby
McLaughlin, C. P.	Pendleton	Madison	Miller, Galen R.	Minot, N.D.	Elkhart
McLaughlin, G. C.	Terre Haute	Vigo	Miller, H. Allison	Marion	Grant
McLaughlin, James R.	Flora	Carroll	Miller, H. L. (S)	West Baden	Orange
McLean, James S.	Hammond	Lake	Miller, Harold E.	Seymour	Jackson
McLelland, Mary R.	Bloomington	Owen-Monroe	Miller, H. Paul	Ft. Wayne	Allen
McMahan, Virgil	Vincennes	Knox	Miller, Hugh A.	Elkhart	Elkhart
McMichael, F. J.	Gary	Lake	Miller, J. Don	Indianapolis	Marion
McMillan, F. G.	Indianapolis	Marion	Miller, James C.	Greensburg	Decatur
McNabb, G. B.	Carthage	Rush	Miller, Joseph A.	Indianapolis	Marion
McNabb, Richard C.	Carthage	Rush	Miller, LaVerne B.	Evansville	Vanderburgh
McNamara, John P.	Indianapolis	Marion	Miller, M. E.	Goshen	Elkhart
McNaughton, L. M.	Washington	Daviess- Martin	Miller, Mahlon F.	Ft. Wayne	Allen
McNeely, M. J.	Dillsboro	Dearborn- Ohio	Miller, Milton	Evansville	Vanderburgh
McQuiston, R. J.	Indianapolis	Marion	Miller, Milo	South Bend	St. Joseph
McTurnan, Robert W.	Indianapolis	Marion	Miller, Minor	Evansville	Vanderburgh
McVey, Clarence A.	Hammond	Lake	Miller, Orval J.	Ft. Wayne	Allen
McWilliams, W. B.	Liberty	Wayne-Union	Miller, R. S.	Indianapolis	Marion
Mead, C. H.	Bluffton	Wells	Miller, Ray D.	Martinsville	Morgan
Mead, Frank E.	LaPorte	LaPorte	Miller, Richard C.	Shelbyville	Shelby
Meade, Walter W.	Bicknell	Knox	Miller, Richard H.	Ft. Wayne	Allen
Meador, Eric B.	Indianapolis	Marion	Miller, Robert B.	Fort Wayne	Allen
Medcalf, Norman L.	Lamar	Spencer	Miller, Robert J.	Evansville	Vanderburgh
Megenhardt, D. S.	Indianapolis	Marion	Miller, Roland E.	Lafayette	Tippecanoe
Mehl, Rudolph A.	Evansville	Vanderburgh	Miller, S. J.	W. Lafayette	Tippecanoe
Mehne, Richard G.	Brazil	Clay	Miller, S. T.	Elkhart	Elkhart
Meikle, Louise J.	W. Lafayette	Tippecanoe	Miller, Virgil	Akron	Fulton
Meiks, Lyman T.	Indianapolis	Marion	Miller, Wallace	Indianapolis	Marion
Meiner, J. A.	Kokomo	Howard	Miller, Wm. A.	Hagerstown	Henry
Meiser, Robert	Huntington	Huntington	Milleson, Ann L. M.	Terre Haute	Vigo
Meister, Doris (S)	Anderson	Madison	Millis, Robert J.	Crawfordsville	Montgomery
Melloh, A. F.	Indianapolis	Marion	Mills, Fred E.	Evansville	Vanderburgh
Mendelson, Stanley M.	Kokomo	Howard	Mills, J. F.	Wabash	Wabash
Mendenhall, Clarence D.	Indianapolis	Marion	Milne, Walter S.	Michigan City	LaPorte
Mendenhall, Edgar	Ft. Wayne	Allen	Milroy, Robert A.	Valparaiso	Porter
Mendez, Carlos	Elkhart	Elkhart	Minczewski, Richard C.	Gary	Lake
Mensch, James R.	Fort Wayne	Allen	Minick, Linus	Churubusco	Whitley
Mentendiek, M. H.	Indianapolis	Marion	Mininger, Edward P.	Elkhart	Elkhart
Mercer, Arthur H.	Gary	Lake	Mino, Raymond W.	Evansville	Vanderburgh
Mercer, Samuel R.	Ft. Wayne	Allen	Mino, Robert A.	Evansville	Vanderburgh
Merchant, Raymond	Lake Village	Jasper- Newton	Mintz, Alfred M.	Marion	Grant
Meredith, E. J.	Richmond	Wayne-Union	Mirro, John A.	Lowell	Lake
Mericle, Earl W.	Indianapolis	Marion	Misch, William	Cedar Lake	Lake
Merrell, B. M.	Rockville	Parke- Vermillion	Mishkin, Irving	Elkhart	Elkhart
Merrell, Paul	Indianapolis	Marion	Mitchell, E. T.	Romney	Tippecanoe
Mertz, H. O.	Indianapolis	Marion	Mitchell, Earl H.	Indianapolis	Marion
Mertz, John H. O.	Indianapolis	Marion	Mitchell, Edward O.	Indianapolis	Marion
Messer, F. W.	Kendallville	Noble	Mitchell, G. L.	Smithville	Owen-Monroe
Metcalf, George B.	Anderson	Madison	Mitchell, R. E.	Springfield, Missouri	Marion
Metcalf, G. E.	South Bend	St. Joseph	Mitman, F. B.	Huntington	Huntington
Meyer, Hans	Butlerville	Jennings	Moats, C. F.	Ft. Wayne	Allen
Meyer, Herman A.	Ft. Wayne	Allen	Moats, G. E.	Ft. Wayne	Allen
Meyer, K. T.	Evansville	Vanderburgh	Modisett, Jackson W.	Madison	Jefferson- Switzerland
Meyer, Milo G.	Michigan City	La Porte	Modisett, Marcella S.	Madison	Jefferson- Switzerland
Meyer, Orlando L.	Bedford	Lawrence	Modjeski, Joseph R.	Hammond	Lake
Meyer, R. C.	Vincennes	Knox	Modjeski, Raymond J.	Hammond	Lake
Meyer, Theodore O.	Ft. Wayne	Allen	Moehlenkamp, C. E.	Evansville	Vanderburgh
			Moeller, Victor C.	Fort Wayne	Allen
			Moening, W. P.	Indianapolis	Marion

Name	City	County
Mohler, Floyd W.	Columbus	Bartholomew- Brown
Molenda, Robert V.	Michigan City	LaPorte
Molengraff, C. J.	Gary	Lake
Molloy, W. J. (S)	Muncie	Delaware- Blackford
Molt, W. F. (S)	Indianapolis	Marion
Monroe, F. Bruce	Crown Point	Lake
Montgomery, L. G.	Muncie	Delaware- Blackford
Montgomery, Wm. F.	Indianapolis	Marion
Moon, Charles E.	Centerpoint	Clay
Moore, B. B.	Indianapolis	Marion
Moore, Edwin G.	Gary	Lake
Moore, E. Gregory	Gary	Lake
Moore, H. T.	Indianapolis	Marion
Moore, Richard B.	Indianapolis	Marion
Moore, R. G.	Vincennes	Knox
Moore, Will C.	Muncie	Delaware- Blackford
Moosey, Louis	Union Mills	LaPorte
Moran, Mark M.	Portland	Jay
Moran, Noel D.	Versailles	Ripley
Moravec, Arthur E.	Ft. Wayne	Allen
Morchan, Samuel	Indianapolis	Marion
Morec, George J.	Smoky Hill A.F.B., Kans.	Marion
Morgan, Margaret E.	Indianapolis	Marion
Morgan, S. P.	LaPorte	LaPorte
Moriarty, John R.	Indianapolis	Marion
Morrical, Russell J.	Logansport	Cass
Morris, Hyman	Gary	Lake
Morris, J. W.	Muncie	Delaware- Blackford
Morris, Robert A.	Anderson	Madison
Morris, Warren V.	Monticello	White
Morris, W. F. (S)	Princeton	Gibson
Morrison, John S. (S)	Lafayette	Tippecanoe
Morrison, J. T.	Greensburg	Decatur
Morrison, Lindsey (S)	Hammond	Lake
Morrison, Lewis E. II	Indianapolis	Marion
Morrison, W. R.	Kokomo	Howard
Morrow, George W.	Logansport	Cass
Mortenson, L. J.	Ft. Wayne	Allen
Morton, Walter P.	Indianapolis	Marion
Moser, E. B. (S)	Windfall	Tipton
Moser, Edward (S)	Woodburn	Allen
Moser, R. H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Mosier, Jack M.	Indianapolis	Marion
Moss, Bobby L.	Indianapolis	Marion
Moss, Harlan B.	Indianapolis	Marion
Moss, Herschel C.	Indianapolis	Marion
Moss, M. J.	Yorktown	Delaware- Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, M. H.	Indianapolis	Marion
Mott, C. A.	South Bend	St. Joseph
Moulton, Lillian	Indianapolis	Marion
Mount, M. S.	Bloomfield	Greene
Mount, Wm. M.	Crawfordsville	Montgomery
Mountain, Francis	Connersville	Fayette- Franklin
Muelchi, Adeline F.	Evansville	Vanderburgh
Mueller, Hilbert M.	South Bend	St. Joseph
Mueller, Lawrence W.	Ft. Wayne	Allen
Mueller, Lillian B.	Indianapolis	Marion
Muhleman, C. E.	LaPorte	LaPorte
Mull, P. L. (S)	Louisville, Ky.	Washington
Muller, Lullus P.	Indianapolis	Marion
Muller, Paul F.	Indianapolis	Marion
Muller, Victor H.	Indianapolis	Marion
Mumford, E. B. (S)	Indianapolis	Marion

Name	City	County
Muncie, Henry L. (S)	Cloverland	Clay
Munk, C. E.	Kendallville	Noble
Murdock, H. L.	Ft. Wayne	Allen
Murphy, E. C.	South Bend	St. Joseph
Murphy, E. W.	New Albany	Floyd
Murphy, Edward U.	Evansville	Vanderburgh
Murphy, Harold O.	Warsaw	Kosciusko
Murphy, Harry	Franklin	Johnson
Murphy, Joseph F., Jr.	Lansing, Ill.	Lake
Murphy, Josephine	South Bend	St. Joseph
Murphy, M. G.	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, Jas. S., Jr.	Beverly Hills, Calif.	Marion
Murray, William W.	Madison	Jefferson- Switzerland
Musacchio, Frederick A.	Hammond	Lake
Musselman, G. G.	Terre Haute	Vigo
Myers, Charles W.	Indianapolis	Marion
Myers, R. V.	Indianapolis	Marion
Myers, Wm. C.	Dana	Parke- Vermillion
N		
Nafe, C. A.	Indianapolis	Marion
Nagan, Robert F.	Indianapolis	Marion
Nahrwold, Elmer W.	Ft. Wayne	Allen
Nakadate, Katsumi J.	Hammond	Lake
Nance, W. K.	Vincennes	Knox
Napper, Floyd	Scottsburg	Scott
Nash, Charles B.	Valparaiso	Porter
Nash, Justin R.	Albion	Noble
Nason, R. A.	Garrett	DeKalb
Nassef, George	Walkerton	St. Joseph
Navin, Hugh K.	Fortville	Hancock
Nay, E. O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Marion
Neale, Alfred E.	Anderson	Madison
Need, Louis T.	Indianapolis	Marion
Neely, A. S. (S)	New Middletown	Harrison- Crawford
Neidballa, E. G.	Bristol	Elkhart
Neifert, Noel	Tell City	Perry
Nelson, Carl A.	West Lebanon	Fountain- Warren
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Harold E.	Muncie	Delaware- Blackford
Nelson, Paul Leon	Anderson	Madison
Nelson, Raymond	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (S)	Evansville	Vanderburgh
Nesbit, L. L.	Anderson	Madison
Nester, Henry G.	Indianapolis	Marion
Netherton, C. R.	Chalmers	White
Neucks, Howard C.	North Vernon	Jennings
Neudorff, Louis G.	Terre Haute	Vigo
Neukamp, Frank H.	Connersville	Fayette- Franklin
Neumann, K. O.	Lafayette	Tippecanoe
Neuwalt, Frank	Gary	Lake
Newby, Eugene	Sheridan	Hamilton
Newcomb, Wm. K.	Royal Center	Cass
Newcomber, Frank V.	Elwood	Madison
Newland, A. E.	Bedford	Lawrence
Newman, A. E.	Evansville	Vanderburgh
Newnum, Raymond L.	Hagerstown	Wayne-Union
Nicholas, Dennis	Indianapolis	Marion
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Wm. E. (S)	Hammond	Lake
Nichols, Wm. G., Jr.	Philadelphia, Pa.	Jefferson- Switzerland
Nickel, Allen C.	Bluffton	Wells
Nicosia, J. B.	East Chicago	Lake







Name	City	County
Permer, Erwin	Indianapolis	Marion
Perrin, K. F.	Ft. Wayne	Allen
Perry, F. G.	Ft. Wayne	Allen
Person, Theodore	Peru	Miami
Perucco, Leo G.	Indianapolis	Marion
Peters, Elmer E.	Brookville	Fayette-Franklin
Peterson, Joel A.	Lafayette	Tippecanoe
Petitjean, H. G.	Haubstadt	Gibson
Petranoff, T. V.	Indianapolis	Marion
Petrass, Andrew	South Bend	St. Joseph
Pettijohn, F. L. (S)	Indianapolis	Marion
Petway, Allen P.	Madison	Jefferson-Switzerland
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, Dudley	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Pfuetze, Max	Logansport	Cass
Phares, Robert W.	Kokomo	Howard
Phelps, Stephen R.	South Bend	St. Joseph
Philbrook, Seth S.	LaPorte	LaPorte
Phillips, David L.	Indianapolis	Marion
Phillips, John F.	Bluffton	Wells
Phillips, William R. (S)	Glenwood	Fayette-Franklin
Phipps, Leland K.	Union City	Randolph
Piazza, Leonard F.	Michigan City	LaPorte
Pickett, Paul	Clinton	Parke-Vermillion
Pickett, Merle E.	Fort Wayne	Allen
Pickett, Robert D.	Indianapolis	Marion
Pierce, Emmett, Jr.	Attica	Fountain-Warren
Pierce, Gene Stratton	New Albany	Floyd
Pierce, H. J.	Terre Haute	Vigo
Pierce, Wm. J.	Indianapolis	Marion
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pietz, David G.	Indianapolis	Marion
Pike, Warren H.	Hobart	Lake
Pilcher, Jack	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	LaPorte
Pilot, Jean	Hammond	Lake
Pippenger, W. G.	Brook	Jasper-Newton
Pirkle, H. B.	Rockville	Parke-Vermillion
Pitkin, Edward M.	Martinsville	Morgan
Pitkin, M. C.	Martinsville	Morgan
Pizzo, Anthony	Bloomington	Owen-Monroe
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	LaPorte
Plautz, Geraldine Z.	Indianapolis	Marion
Ploetner, Edward J.	Jasper	Dubois
Ploughe, R. R.	Elwood	Madison
Polhemus, Gretchen I.	New Albany	Floyd
Polhemus, Warren C.	Anderson	Madison
Pollard, Walter	Evansville	Vanderburgh
Pollock, Anthony J.	Indianapolis	Marion
Pomeroy, Rex K.	Plymouth	Marshall
Poncher, Henry G.	Valparaiso	Porter
Ponczek, Edward	Fort Wayne	Allen
Pontius, Edwin E.	Fort Wayne	Allen
Poolitson, Geo. C.	Bloomington	Owen-Monroe
Popplewell, Arvine G.	Indianapolis	Marion
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, Dale	Indianapolis	Marion
Porter, George C. (S)	Linton	Greene
Porter, Jack	Lebanon	Boone
Porter, Robert A.	Westport	Decatur
Portteus, Walter L.	Franklin	Johnson
Poston, C. L.	Laurel	Fayette-Franklin

Name	City	County
Potter, Brian	Michigan City	LaPorte
Potter, Richard M.	Ridgeville	Randolph
Potter, Thomas P., Jr.	South Bend	St. Joseph
Powell, Edgar H. (S)	Valparaiso	Porter
Powell, J. Paxton	Marion	Grant
Prather, Philip E.	Kokomo	Howard
Predd, Adolph C.	LaPorte	LaPorte
Premuda, F. E.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson-Switzerland
Prentiss, Nelson M.	Otenne, N.C.	Allen
Present, Julian	Evansville	Vanderburgh
Price, Douglas W.	Nappanee	Elkhart
Price, Francis W.	Indianapolis	Marion
Price, James O.	Indianapolis	Marion
Price, Shirley G.	Evansville	Vanderburgh
Priebe, Fred H.	Hillsboro	Fountain-Warren
Proudfit, Charles H.	South Bend	St. Joseph
Province, O. A. (S)	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, J. Edward	Gary	Lake
Pryor, R. C.	Indianapolis	Marion
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, B. H.	Wolcottville	Noble
Purcell, Jack H.	Boonville	Warrick
Purcell, Richard J.	Griffith	Lake
Puterbaugh, K. E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph
<b>Q</b>		
Quarles, E. Bryan	Bloomington	Owen-Monroe
Quick, Wm. J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (S)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
<b>R</b>		
Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry	Indianapolis	Marion
Raber, Robert M.	San Diego, Calif.	Marion
Rabson, S. Milton	Ft. Wayne	Allen
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Indianapolis	Marion
Rainey, E. A. (S)	Lebanon	Boone
Ralston, John D.	Portland	Jay
Ramage, W. F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	East Chicago	Lake
Ramsdell, Glen A.	Richmond	Wayne-Union
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, H. S.	Bloomington	Owen-Monroe
Raney, B. B.	Linton	Greene
Rang, A. A.	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Raphael, Isidor J.	Evansville	Vanderburgh
Rasch, George C., Jr.	Hammond	Lake
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratliffe, A. W.	Evansville	Vanderburgh
Rathkey, Arthur S.	Muncie	Delaware-Blackford
Rausch, Norman W.	Angola	Steuben
Ravdin, Bernard	Evansville	Vanderburgh
Rawles, Lyman T. (S)	Ft. Wayne	Allen
Rawlins, Carolyn M.	Hammond	Lake
Ray, Herbert A. (S)	Ft. Wayne	Allen
Rebhun, Joseph	Gary	Lake
Reck, J. L.	Sheridan	Hamilton
Records, A. W.	Franklin	Johnson
Reed, Donald	Culver	Marshall

Name	City	County	Name	City	County
Reed, John J.	Hobart	Lake	Rivers, Glynn A.	Muncie	Delaware-Blackford
Reed, Nelle C.	Michigan City	LaPorte	Robb, John A.	Indianapolis	Marion
Reed, Philip B.	Indianapolis	Marion	Roberts, Thomas K.	Michigan City	LaPorte
Reed, Robert C.	Terre Haute	Vigo	Robertson, A. N.	New Albany	Floyd
Reed, Robert F.	Mishawaka	St. Joseph	Robertson, D. W. (S)	Deputy	Jefferson-Switzerland
Reed, Robert G., Jr.	Plymouth	Marshall	Robertson, James S.	Plymouth	Marshall
Reed, R. R.	Anderson	Madison	Robertson, Ray	Indianapolis	Marion
Reed, Wm. C.	Bloomington	Owen-Monroe	Robertson, W. C.	Chesterton	Porter
Reeder, Henry H.	Jeffersonville	Clark	Robertson, William S.	Spiceland	Henry
Rees, Russell C.	Indianapolis	Marion	Robinson, Earl U.	Evansville	Vanderburgh
Reese, Lawrence W.	Culver	Marshall	Robinson, Frank C.	St. Petersburg, Fla.	Marion
Regan, George L.	Sellersburg	Clark	Robinson, Walter K.	Gary	Lake
Reich, Clarence E.	Evansville	Vanderburgh	Robison, J. S.	Winchester	Randolph
Reid, Chas. A.	Indianapolis	Marion	Robrock, Lawrence M.	Michigan City	LaPorte
Reid, Robert M.	Columbus	Bartholomew-Brown	Roby, A. L.	Jeffersonville	Clark
Reid, Robert W.	Union City	Randolph	Rockey, Noah A.	Ft. Wayne	Allen
Reilly, James F.	Vincennes	Knox	Rodin, Herman H.	South Bend	St. Joseph
Reisler, Simon	Indianapolis	Marion	Rodriguez, Juan	Ft. Wayne	Allen
Reitz, Thomas F.	Evansville	Vanderburgh	Roesch, Ryland	Warsaw	Kosciusko
Remich, A. C.	Hammond	Lake	Rogers, Arthur R.	Newburgh	Warrick
Renbarger, L. L.	Marion	Grant	Rogers, Donald L.	Indianapolis	Marion
Rendel, D. T.	Hammond	Lake	Rogers, Evered E.	Auburn	DeKalb
Rendel, H. E.	Mexico	Miami	Rogers, O. F.	Bloomington	Owen-Monroe
Reppert, Roland L.	Decatur	Adams	Rogers, Thomas P.	San Diego, Calif.	Marion
Rettig, A. C.	Muncie	Delaware-Blackford	Roggenkamp, Milton W.	New Albany	Floyd
Reynolds, D. M. (S)	Garrett	DeKalb	Rohn, Robert J.	Indianapolis	Marion
Reynolds, J. S.	Gary	Lake	Rohr, Joseph H.	Elkhart	Elkhart
Reynolds, R. P.	Garrett	DeKalb	Rohrer, J. R.	Elnora	Daviess-Martin
Reynolds, Richard J.	Terre Haute	Vigo	Roller, C. W. (S)	Indianapolis	Marion
Rhamy, A. P.	Wabash	Wabash	Rollins, Thomas K.	Bloomington	Owen-Monroe
Rhea, G. D.	Greencastle	Putnam	Romberger, Floyd T., Jr.	Indianapolis	Marion
Rhea, James C.	Beech Grove	Marion	Rommel, Clarence H.	W. Lafayette	Tippecanoe
Rhind, A. W.	Hammond	Lake	Roose, Lisle W.	Nappanee	Elkhart
Rhodes, Theodore D.	Indianapolis	Marion	Ropp, Eldon R.	Oakland City	Gibson
Rhorer, H. M.	Kokomo	Howard	Ropp, H. E.	New Harmony	Posey
Rhorer, John G.	Marion	Grant	Rosenak, Bernard D.	Indianapolis	Marion
Rice, Frederic A.	Indianapolis	Marion	Rosenbaum, David	Indianapolis	Marion
Rice, Raymond M.	Indianapolis	Marion	Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rice, W. B.	Ft. Wayne	Allen	Rosenbaum, L. E.	Anderson	Madison
Richard, Norman F.	Shelbyville	Shelby	Rosenblatt, B. B.	Evansville	Vanderburgh
Richards, D. H. (S)	Vincennes	Knox	Rosenbloom, P. J.	Gary	Lake
Richards, E. E.	Russellville	Putnam	Rosenheimer, Geo. M.	South Bend	St. Joseph
Richardson, C. L.	Rochester	Fulton	Rosenthal, Carl	Hammond	Lake
Richardson, Thad T.	Indianapolis	Marion	Rosenwasser, Jacob	Mishawaka	St. Joseph
Richart, J. V.	Terre Haute	Vigo	Roser, A. J.	Ft. Wayne	Allen
Richer, O. H.	Warsaw	Kosciusko	Rosevear, Henry J.	Hammond	Lake
Richter, Arthur B.	Indianapolis	Marion	Ross, Alexander T.	Indianapolis	Marion
Richter, John C.	LaPorte	LaPorte	Ross, Ben R.	Bloomington	Owen-Monroe
Richter, Samuel	Gary	Lake	Ross, Glenn E.	Indianapolis	Madison
Ricketts, J. W.	Indianapolis	Marion	Ross, Guy E.	Anderson	Marion
Ridgeway, O. W. (S)	Indianapolis	Marion	Ross, Harry P.	Richmond	Wayne-Union
Ridgway, Alton H.	Lapel	Madison	Ross, James S.	Richmond	Wayne-Union
Rieger, I. Taylor	Bloomington	Owen-Monroe	Ross, W. W. (S)	La Porte	La Porte
Rifner, E. S.	Van Buren	Grant	Rossiter, D. L.	Ft. Wayne	Allen
Rigg, J. F.	Indianapolis	Marion	Rossow, Russell J.	Evansville	Vanderburgh
Riggs, Floyd	Terre Haute	Vigo	Roth, Bertram	Indianapolis	Marion
Rigley, E. L.	South Bend	St. Joseph	Roth, James	Wolf Lake	Noble
Riley, Frank (S)	Jamestown	Boone	Roth, Leo	Gary	Lake
Ringham, Jarrett	Evansville	Vanderburgh	Rothberg, Maurice J.	Ft. Wayne	Allen
Ringer, Harold C.	Evansville	Vanderburgh	Rothermel, Harold	Union City	Randolph
Rinker, Earl B.	Indianapolis	Marion	Rothring, Howard E.	Columbus	Bartholomew-Brown
Rinne, John I.	Lapel	Madison	Rothrock, Philip W.	Lafayette	Tippecanoe
Riordan, John F.	Highland (Hammond)	Lake	Rothschild, C. J.	Ft. Wayne	Allen
Ripley, John W.	Seymour	Jackson	Rotman, Harry G.	Jasonville	Greene
Rissing, Walter J.	Ft. Wayne	Allen	Rotman, Sam I.	Jasonville	Greene
Ritchey, J. O.	Indianapolis	Marion	Rouen, Robert	Elkhart	Elkhart
Ritchie, William D.	Evansville	Vanderburgh	Row, D. Hamilton	Indianapolis	Marion
Ritteman, George W.	Columbus	Bartholomew-Brown	Row, George S.	Osgood	Ripley
Ritter, Wayne L.	Indianapolis	Marion			
Ritz, Albert S.	Evansville	Vanderburgh			



Name	City	County	Name	City	County
Row, Perrie Q.	Hammond	Lake	Schaefer, William C.	Hicksville, N.Y.	Vanderburgh
Rowe, Howard H.	Rochester	Fulton	Schafer, Donald W.	Topeka, Kan.	Allen
Royster, Robert A.	Evansville	Vanderburgh	Schafer, William C.	Washington	Daviess-
Rozelle, Clarence V.	Anderson	Madison			Martin
Rubens, Eli	South Bend	St. Joseph	Schantz, Richard	Remington	Jasper-
Rubin, Gerald S.	Indianapolis	Marion			Newton
Rubin, Milton M.	Terre Haute	Vigo	Scharbrough, William	Medora	Jackson
Rubin, Simon S.	Gary	Lake	Schauwecker, Cleon M.	Greencastle	Putnam
Ruddell, Karl R.	Indianapolis	Marion	Schechter, John S.	Indianapolis	Marion
Ruddell, Keith R.	Brookline, Mass.	Marion	Scheetz, Marion R.	Lewisville	Henry
Ruddick, H. C.	Evansville	Vanderburgh	Scheier, E. W.	Indianapolis	Marion
Rudesill, C. L.	Indianapolis	Marion	Schell, Harry D.	Bloomington	Owen-Monroe
Rudesill, Robert	Indianapolis	Marion	Schellhouse, Earl	Fort Wayne	Allen
Rudicel, Max	Kokomo	Howard	Schenck, Foss	Logansport	Cass
Rudisill, Robert	Michigan City	LaPorte	Schenck, Ralph E.	Indianapolis	Marion
Rudolph, Carl J.	South Bend	St. Joseph	Scherb, Burton E.	Terre Haute	Vigo
Rudolph, F. G.	Hammond	Lake	Scherschel, John P.	Bedford	Lawrence
Rudolph, Kenneth J.	Boonville	Warrick	Schetgen, Joseph V.	Geneva	Adams
Rudolph, Stephen, Jr.	Scott, A.F.B., Ill.	Marion	Scheurich, Virgil	Oxford	Benton
	Whiting	Lake	Schiller, Herbert A.	South Bend	St. Joseph
Rudser, D. H.	Richmond	Wayne-Union	Schimmelpfennig, Robert W.	Marion	Grant
Runge, Paul W.	Clarksville	Clark	Schirmer, Robert H.	Evansville	Vanderburgh
Ruoff, William	Elkhart	Elkhart	Schlademan, Karl R.	Ft. Wayne	Allen
Rupe, Lloyd O.	Indianapolis	Marion	Schlagel, T. F., Jr.	Indianapolis	Marion
Rupel, Ernest	Evansville	Vanderburgh	Schlegel, Donald M.	Indianapolis	Marion
Rusche, Henry J.	Lafayette	Tippecanoe	Schlegel, Edward H.	Ft. Wayne	Allen
Ruschli, E. B.	Wallace	Fountain-	Schlemmer, George H.	Warsaw	Kosciusko
Rusk, Hubert M.		Warren	Schlesinger, Daniel	Pittsburgh, Pa.	Lake
Rust, Byron K.	Indianapolis	Marion	Schlesinger, Jacob	Hammond	Lake
Ruth, Martin L.	Indianapolis	Marion	Schlosser, H. C.	Elkhart	Elkhart
Rutherford, C. W. (S)	Indianapolis	Marion	Schmidt, Eugene F.	Ft. Wayne	Allen
Rutherford, Charles E.	Otterbein	Benton	Schmidt, Loren F.	Indianapolis	Marion
Ryan, Glen V.	Indianapolis	Marion	Schmidt, Richard H.	Indianapolis	Marion
Ryan, H. J.	Gary	Lake	Schmiedicke, P. H.	Lafayette	Tippecanoe
Ryan, William J.	Columbus	Bartholomew-	Schmitt, Richard K.	Columbus	Bartholomew-
		Brown			Brown
S			Schmoll, Robert J.	Ft. Wayne	Allen
Sage, Charles V., Jr.	Richmond	Wayne-Union	Schneider, Carl J.	Indianapolis	Marion
Sage, Russell	Indianapolis	Marion	Schneider, C. P.	Evansville	Vanderburgh
Sagel, Jacob	Gary	Lake	Schneider, Kenneth	Nashville	Bartholomew-
Sahlman, Hans	Ft. Wayne	Allen			Brown
Saint, William	New Castle	Henry	Schneider, Louis A.	Ft. Wayne	Allen
Sala, J. J.	Gary	Lake	Schoen, Frederic L.	Ft. Wayne	Allen
Sala, Walter R.	Gary	Lake	Schoolfield, Wm. E.	Orleans	Orange
Salb, John P.	Indianapolis	Marion	Schott, Edward J. (S)	Terre Haute	Vigo
Salb, Leo A.	Jasper	Dubois	Schreiner, John E.	Bremen	Marshall
Salb, Max C.	Indianapolis	Marion	Schrepferman, Wayne	Hamilton	Steuben
Sallee, William T.	Greensburg	Decatur	Schriefer, Victor V.	Evansville	Vanderburgh
Salon, Harry W.	Ft. Wayne	Allen	Schroeder, Henry	Louisville, Ky.	Daviess-
Salon, Joel W.	Ft. Wayne	Allen			Martin
Salon, N. L.	Ft. Wayne	Allen	Schuchman, Abe	Indianapolis	Marion
Salzman, Morris	Indianapolis	Marion	Schuchman, Gabriel	Indianapolis	Marion
Samples, J. T. (S)	Boonville	Warrick	Schuldt, T. S.	Pierceton	Kosciusko
Sanders, Harry M.	Indianapolis	Marion	Schulfer, Richard J.	Hammond	Lake
Sanders, J. A.	Auburn	De Kalb	Schulhof, M. G.	Muncie	Delaware-
Sanderson, R. B.	South Bend	St. Joseph			Blackford
Sandock, Isadore	South Bend	St. Joseph	Schulz, Dale M.	Indianapolis	Marion
Sandock, Louis F.	South Bend	St. Joseph	Schulze, Wm.	Vincennes	Knox
Sandorf, M. H.	Indianapolis	Marion	Schumaker, Robert A.	Terre Haute	Vigo
Sandoz, Harry	South Bend	St. Joseph	Schuman, Edith B.	Bloomington	Owen-Monroe
Santare, Vincent J.	Hammond	Lake	Schuster, Dwight W.	Indianapolis	Marion
Saperstein, Morris	Muncie	Delaware-	Schutt, J. B.	Ligonier	Noble
		Blackford	Schwartz, Fred C.	Kokomo	Howard
Sarver, Francis E.	Fort Wayne	Allen	Scoins, W. H.	Ft. Wayne	Allen
Savage, A. R.	Ft. Wayne	Allen	Scott, Frank M.	South Bend	St. Joseph
Savery, C. E.	South Bend	St. Joseph	Scott, G. D.	Sullivan	Sullivan
Savory, Paul B.	Bluffton	Wells	Scott, George E.	Indianapolis	Marion
Sayers, F. E.	Terre Haute	Vigo	Scott, H. V.	Ft. Wayne	Allen
Scamahorn, Malcolm O.	Pittsboro	Hendricks	Scott, Irvin H.	Sullivan	Sullivan
Scamahorn, O. T.	Pittsboro	Hendricks	Scott, I. W.	Indianapolis	Marion
Scea, Wallace	Elwood	Madison	Scott, John S.	LaPorte	LaPorte
Schaaf, Alvin	Jamestown	Boone	Scott, John R.	Indianapolis	Marion
Schaefer, C. R. (S)	Indianapolis	Marion	Scott, Robert P.	Indianapolis	Marion
			Scott, Robert S.	Charlottesville	Hancock



Name	City	County	Name	City	County
Scott, S. L.	Indianapolis	Marion	Shrigley, Edw. W.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby	Shriner, Richard L.	Indianapolis	Marion
Scudder, A. N.	Brownsburg	Hendricks	Shrock, E. E.	Amboy	Miami
Scudder, J. A.	Edwardsport	Knox	Shroyer, Herbert	Dunkirk	Jay
Seagle, William C.	Indianapolis	Marion	Shuck, Wm. A.	Madison	Jefferson-Switzerland
Seal, Perry F.	Brookville	Fayette-Franklin	Shugart, Joseph D.	El Paso, Tex.	Marion
Seaman, C. F.	Indianapolis	Marion	Shullenberger, W. A.	Indianapolis	Marion
Sears, Don	Odon	Daviess-Martin	Shulruff, H. I.	East Chicago	Lake
Sears, M. Maywood (S)	Elkhart	Elkhart	Shultz, H. M. (S)	Logansport	Cass
Seat, Marshall H.	Washington	Daviess-Martin	Shumacker, H. B., Jr.	Indianapolis	Marion
Sedam, Herbert L.	Indianapolis	Marion	Sibbitt, Joseph W.	Bloomington	Owen-Monroe
Seese, Robert M.	Delphi	Carroll	Sicks, O. W.	Indianapolis	Marion
Segar, Louis H.	Indianapolis	Marion	Sidebottom, Earl	Indianapolis	Marion
Seibel, Robert	Morgantown	Morgan	Siebenmorgen, Louis	Terre Haute	Vigo
Seitz, P. F. D.	Indianapolis	Marion	Siebenmorgen, Paul	Terre Haute	Vigo
Selby, K. E.	South Bend	St. Joseph	Siegmán, Edw. L.	Terre Haute	Vigo
Sellers, Francis M.	South Bend	St. Joseph	Siekerman, C. W.	Indianapolis	Marion
Sellmer, George W.	Indianapolis	Marion	Siekierski, J. M.	Griffith	Lake
Selsam, Etta B.	Terre Haute	Vigo	Siersdorfer, T. N. (S)	Indianapolis	Marion
Senese, T. J.	Gary	Lake	Sigmond, Harvey W.	Indianapolis	Marion
Sennett, C. M.	Westville	LaPorte	Sigmund, Wm. B.	Columbus	Bartholomew-Brown
Sennett, Wm. K.	Macy	Miami	Silbert, David	Shelbyville	Shelby
Sensenich, R. L.	South Bend	St. Joseph	Silverman, Norman M.	Terre Haute	Vigo
Senseny, Eugene F.	Fort Wayne	Allen	Silver, Richard A.	Muncie	Delaware-Blackford
Senseny, Herbert	Ft. Wayne	Allen	Silvian, Harry	Whiting	Lake
Seward, G. W.	N. Manchester	Wabash	Simmons, Frederick H.	Marion	Grant
Sexson, Hiram	Indianapolis	Marion	Simmons, James E.	Indianapolis	Marion
Seybert, J. D.	Kendallville	Noble	Simmons, L. H.	Goshen	Elkhart
Seyler, Anna G.	Crown Point	Lake	Simms, J. Leon	Indianapolis	Marion
Shafer, Marion R.	Indianapolis	Marion	Simon, A. R.	La Porte	La Porte
Shafer, Richard H.	Alexandria	Madison	Simpson, Wm. D.	Indianapolis	Marion
Shafer, Sid J.	Chicago, Ill.	Lake	Sims, J. Lawrence	Indianapolis	Marion
Shaffer, K. L.	Vincennes	Knox	Singer, E. C.	Ft. Wayne	Allen
Shaffer, William R.	Greensburg	Decatur	Sirlin, E. M.	Mishawaka	St. Joseph
Shallenberger, H. R.	Modoc	Randolph	Sisson, Helen M.	Westville	LaPorte
Shanafelt, Donald K.	Indianapolis	Marion	Skeen, E. D.	Gary	Lake
Shanklin, E. M. (S)	Hammond	Lake	Skilern, P. G.	South Bend	St. Joseph
Shanklin, V. A.	Terre Haute	Vigo	Skomp, Claud E.	Marion	Grant
Shanks, Ray W.	Noblesville	Hamilton	Skrentny, Stanley	Hammond	Lake
Shapiro, Burton J.	Terre Haute	Vigo	Slabaugh, J. S. (S)	Nappanee	Elkhart
Shapiro, Joseph	East Chicago	Lake	Slama, George	Gary	Lake
Sharp, John L.	Crawfordsville	Montgomery	Slama, John T.	Gary	Lake
Sharp, Merle C.	South Bend	St. Joseph	Slaughter, Howard C.	Evansville	Vanderburgh
Sharp, W. L.	Anderson	Madison	Slaughter, John	Evansville	Vanderburgh
Shattuck, John C.	Brazil	Clay	Slaughter, Owen L.	Evansville	Vanderburgh
Sheehan, Francis G.	Indianapolis	Marion	Slick, C. R.	Lynn	Randolph
Sheek, Kenneth I.	Greenwood	Johnson	Slimp, Thomas E.	Logansport	Cass
Sheets, Charles E.	Manilla	Rush	Sloan, H. P.	New Albany	Floyd
Sheller, Thomas G.	Argos	Marshall	Slominski, H. H.	South Bend	St. Joseph
Shelley, Edward	South Bend	St. Joseph	Sloss, I. H.	Terre Haute	Vigo
Shellhouse, Michael	Gary	Lake	Sluss, David H.	Indianapolis	Marion
Shenk, E. M.	Kokomo	Howard	Sluss, John W. (S)	Indianapolis	Marion
Shepard, Fred F.	College Corner, Ohio	Wayne-Union	Smallwood, R. B.	Bedford	Lawrence
Sherman, Robert M.	Bluffton	Wells	Smelser, H. W.	Connersville	Fayette-Franklin
Sherster, Harry	Indianapolis	Marion	Smith, B. J.	Kingman	Fountain-Warren
Sherwood, Clarence	Fort Wayne	Allen	Smith, Charles F.	Indianapolis	Marion
Sherwood, J. V.	Ft. Wayne	Allen	Smith, Charles G.	Otterbein	Benton
Shevick, Alexander	Gary	Lake	Smith, David J.	Indianapolis	Marion
Shields, Harry A.	Washington	Daviess-Martin	Smith, D. L.	Indianapolis	Marion
Shields, Jack E.	Brownstown	Jackson	Smith, Don C.	Columbus	Bartholomew-Brown
Shields, Tom S.	Richmond	Wayne-Union	Smith, Edward B.	Indianapolis	Marion
Shinabery, Lawrence	Ft. Wayne	Allen	Smith, E. Rogers	Indianapolis	Marion
Shively, John A.	Bluffton	Wells	Smith, Francis C.	Indianapolis	Marion
Sholty, W. M.	Lafayette	Tippecanoe	Smith, Frederick R.	Spencer	Owen-Monroe
Shonk, Harold W.	Noblesville	Hamilton	Smith, G. A.	New Haven	Allen
Short, John	Ft. Wayne	Allen	Smith, Gloster J.	Kokomo	Howard
Shortall, James P.	Michigan City	LaPorte	Smith, H. N.	Brookville	Fayette-Franklin
Shortridge, W. H.	Seymour	Jackson	Smith, H. S.	Bloomington	Owen-Monroe
Shoup, H. B.	Greentown	Howard	Smith, James S.	Muncie	Delaware-Blackford
Showalter, John P.	Waterloo	De Kalb			
Showalter, John R.	Terre Haute	Vigo			

Name	City	County	Name	City	County
Smith, John R.	Richmond	Wayne-Union	Sroka, Stanley J.	Hobart	Lake
Smith, L. C.	Indianapolis	Marion	Stadler, Harold E.	Indianapolis	Marion
Smith, Lee	Lakeville	St. Joseph	Staff, Robert A.	Rockville	Parke-Vermillion
Smith, Lester A.	Indianapolis	Marion			
Smith, Marsh H.	Goodland	Jasper-Newton	Stafford, J. C.	Plainfield	Hendricks
			Stafford, W. C.	Plainfield	Hendricks
Smith, Paul E.	Bloomington	Owen-Monroe	Stahl, Edward	Lafayette	Tippecanoe
Smith, Philip L.	Ft. Wayne	Allen	Stallman, Carl F.	Kendallville	Noble
Smith, Ralph O.	Vincennes	Knox	Stalter, Gaylord W.	N. Webster	Kosciusko
Smith, R. D. (S)	Bloomington	Owen-Monroe	Stamper, J. H.	Anderson	Madison
Smith, R. Lee	Osgood	Ripley	Stamper, L. Allen	Richmond	Wayne-Union
Smith, Richard B.	New Haven	Allen	Stamper, Robert J.	Anderson	Madison
Smith, Roy L.	Indianapolis	Marion	Stangle, W. J.	Bloomington	Owen-Monroe
Smith, S. Joseph	Vincennes	Knox	Stanley, John R.	Muncie	Delaware-Blackford
Smith, T. J.	Whiting	Lake			
Smith, Wilbur F.	Indianapolis	Marion	Stanley, J. S.	Indianapolis	Marion
Smith, William B.	Indianapolis	Marion	Stanton, J. J.	Logansport	Cass
Smoot, Emory B.	Washington	Daviess-Martin	Starks, William O.	Muncie	Delaware-Blackford
Smoots, S. A.	Terre Haute	Vigo	Stasick, Murray	Hammond	Lake
Snapp, Richard A.	Indianapolis	Marion	Staten, Jesse C.	Indianapolis	Marion
Sneary, K. D.	Avilla	Noble	Stauffer, George E.	Mooreland	Henry
Snider, Byron	Indianapolis	Marion	Stauffer, Richard C.	Ft. Wayne	Allen
Snively, W. D., Jr.	Evansville	Vanderburgh	Stauffer, Walter A. (S)	Elkhart	Elkhart
Snyder, E. R.	Troy	Perry	Staunton, Henry A.	South Bend	St. Joseph
Snyder, Morris C.	Richmond	Wayne-Union	Stayton, C. A.	Indianapolis	Marion
Snyderman, Sanford C.	Fort Wayne	Allen	Stayton, Chester A., Jr.	Indianapolis	Marion
Solomon, R. A.	Indianapolis	Marion	Steckler, Robert J.	Evansville	Vanderburgh
Solomon, Robert D.	Terre Haute	Vigo	Stecy, Peter	Whiting	Lake
Somers, G. H.	Ft. Wayne	Allen	Steele, Dick J.	Greencastle	Putnam
Somers, William H.	Indianapolis	Marion	Steele, E. B.	Crown Point	Lake
Soper, Hunter A.	Indianapolis	Marion	Steele, Hugh H.	Lafayette	Tippecanoe
Sorenson, Raymond	Kokomo	Howard	Steele, Paul W.	Evansville	Vanderburgh
Souder, Bonnell M.	Auburn	De Kalb			
Souter, Martha C.	Indianapolis	Marion	Steen, Lowell H.	Whiting	Lake
Southard, C. B.	Noblesville	Hamilton	Steffen, A. J.	Wabash	Wabash
Southard, James E.	Indianapolis	Marion	Steffen, J. T.	Wabash	Wabash
Southworth, John W.	Madison	Jefferson-Switzerland	Steffy, Ralph M.	Portland	Jay
			Steinem, Joseph L.	Connersville	Fayette-Franklin
Sovine, Joe W.	Indianapolis	Marion	Steinkamp, Emil F.	Huntingburg	Dubois
Spahr, D. E.	Portland	Jay	Steinman, H. E.	Monroeville	Allen
Spahr, John F.	Indianapolis	Marion	Stellner, Howard A.	Ft. Wayne	Allen
Spalding, J. J.	Indianapolis	Marion	Stemm, W. H. (S)	North Vernon	Jennings
Spalding, W. L.	Mishawaka	St. Joseph	Stephens, Donald E.	Indianapolis	Marion
Spangler, Jesse S.	Kokomo	Howard	Stephens, K. H.	Indianapolis	Marion
Sparks, Alan L.	Indianapolis	Marion	Stephens, Lowell R.	Covington	Mountain-Warren
Sparks, Paul W.	Winchester	Randolph			
Spears, John K.	Paoli	Orange	Stepleton, John D.	Richmond	Wayne-Union
Spears, John M.	Hobart	Lake	Stern, Nathan	Indianapolis	Marion
Speas, Robert C.	Terre Haute	Vigo	Stern, S. L.	Hammond	Lake
Speckman, Glenn H.	Indianapolis	Marion	Sterne, John H.	Evansville	Vanderburgh
Spellman, Frank A.	Gary	Lake	Stevens, Edwin W.	Hammond	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe	Stevens, S. L.	Indianapolis	Marion
Spencer, Frederic	Vincennes	Knox	Stewart, Milton B. (S)	Logansport	Cass
Spenner, R. W.	South Bend	St. Joseph	Stewart, O. H.	Aurora	Dearborn-Ohio
Spieth, Wm. H.	Lebanon	Boone			
Spigler, James	Terre Haute	Vigo	Stewart, W. E.	Terre Haute	Vigo
Spindler, Robert D.	Shelbyville	Shelby	Sthair, Phillip L.	Marion	Grant
Spinning, Alva (S)	Michigan City	LaPorte	Stier, Paul L.	Ft. Wayne	Allen
Spivack, Mary	Gary	Lake	Stillwell, William R.	Richmond	Wayne-Union
Spivey, R. J.	Indianapolis	Marion	Stimson, H. R.	Gary	Lake
Spolyar, L. W.	Indianapolis	Marion	Stine, Marshall E.	Bremen	Marshall
Sponder, Joseph	Gary	Lake	Stinson, A. E. (S)	Rochester	Fulton
Spray, Page E.	Elkhart	Elkhart	Stinson, Dean K.	Rochester	Fulton
Springstun, C. L.	Chrisney	Spencer	Stiver, Daniel	South Bend	St. Joseph
Springstun, George	Oaktown	Knox	Stocking, B. W.	Muncie	Delaware-Blackford
Springstun, W. R.	Evansville	Vanderburgh			
Spurgeon, O. E. (S)	Muncie	Delaware-Blackford	Stoelting, J. Lewis	Terre Haute	Vigo
			Stoelting, V. K.	Indianapolis	Marion
Spurlock, Fae	Topeka, Kan.	Tippecanoe	Stogdill, William J.	South Bend	St. Joseph
Sputh, Carl B., Sr.	Indianapolis	Marion	Stogdill, Willis	Franklin	Johnson
Sputh, Carl B., Jr.	Indianapolis	Marion	Stone, A. T.	Indianapolis	Marion
Sroka, Alexander G.	Highland		Stone, David F.	Indianapolis	Marion
	(Hammond) Lake		Stoops, Jean T.	Wabash	Wabash
			Storer, Wm. R.	Sturgis, Mich.	Lake



Name	City	County	Name	City	County
Storey, D. E.	Indianapolis	Marion	Tennant, David L.	Ft. Wayne	Allen
Storey, Joseph L.	Indianapolis	Marion	Tennis, George	Greencastle	Putnam
Stork, Harvey K.	Huntingburg	Dubois	Teplinsky, L. Louis	Munster	Lake
Stork, Urban	Evansville	Vanderburgh	Terflinger, F. W. (S)	Logansport	Cass
Storms, Roy B.	Indianapolis	Marion	Terrill, R. W.	Ft. Wayne	Allen
Stouder, Albert E.	Kempton	Tipton	Terry, Lloyd	Danville	Hendricks
Stouder, Charles E.	Gosport	Owen-Monroe	Terveer, John B.	Decatur	Adams
Stout, Francis E.	Muncie	Delaware-Blackford	Test, Charles E.	Indianapolis	Marion
			Teter, Geo. V., Jr.	Indianapolis	Marion
Stout, Harry T.	Frankfort	Clinton	Teters, Melvin S.	Middlebury	Elkhart
Stout, R. B.	Elkhart	Elkhart	Tether, Joseph E., Jr.	Indianapolis	Marion
Stout, Walter M.	New Castle	Henry	Tharpe, Ray	Indianapolis	Marion
Stover, Wendell C.	Boonville	Warrick	Thatcher, H. K., Jr.	Indianapolis	Marion
Stoycoff, C. M.	Gary	Lake	Thayer, B. W.	North Vernon	Jennings
Strange, Dempsey C.	Indianapolis	Marion	Thayer, J. O.	Noblesville	Hamilton
Stratigos, Jos. S.	South Bend	St. Joseph	Thegze, George	Whiting	Lake
Strayer, J. W.	Lafayette	Tippecanoe	Theye, Richard A.	Fort Wayne	Allen
Streck, F. A.	Lawrenceburg	Dearborn-Ohio	Thimlar, J. W.	Ft. Wayne	Allen
			Thom, Julia S.	Indianapolis	Marion
Strecker, Wm. L.	Terre Haute	Vigo	Thomas, C. E. (S)	Leesburg	Kosciusko
Streepey, J. I.	New Albany	Floyd	Thomas, Daniel D.	Gary	Lake
Strickland, Karl S.	Owensville	Gibson	Thomas, Edward P.	Indianapolis	Marion
Strickland, Martha B.	Lafayette	Tippecanoe	Thomas, Everett W.	Warsaw	Kosciusko
Strong, Daniel S. (S)	Terre Haute	Vigo	Thomas, Fred A.	Indianapolis	Marion
Stroup, Tyler J.	Indianapolis	Marion	Thomas, G. A.	Lafayette	Tippecanoe
Strueh, Paul E.	Evansville	Vanderburgh	Thomas, Gerald J.	Gary	Lake
Stubbins, William M.	Elkhart	Elkhart	Thomas, Lowell I.	Indianapolis	Marion
Stucky, Ellsworth	Indianapolis	Marion	Thomas, Morris E.	Indianapolis	Marion
Studebaker, Lloyd R.	LaGrange	LaGrange	Thomas, Ralph G.	Ft. Leonard	Marion
Stultz, Q. F.	Ligonier	Noble		Wood, Mo.	
Stumer, Myer	Michigan City	LaPorte	Thompson, A. A. (S)	Tyner	Marshall
Stump, Thomas A.	Indianapolis	Marion	Thompson, Chas. F.	Indianapolis	Marion
Stumpf, Edwin E.	New Haven	Allen	Thompson, Frank	Columbia City	Whitley
Sturgis, Donald G.	Sellersburg	Clark	Thompson, Holland	Ft. Wayne	Allen
Stygall, James H.	Indianapolis	Marion	Thompson, John M.	South Bend	St. Joseph
Sudranski, Herbert F.	Indianapolis	Marion	Thompson, J. V.	Indianapolis	Marion
Sugarman, Benj. E.	French Lick	Orange	Thompson, Paul D.	Indianapolis	Marion
Sullenger, A. A.	Vincennes	Knox	Thompson, Robert A.	South Bend	St. Joseph
Sullivan, John M.	Terre Haute	Vigo	Thompson, W. A. (S)	Liberty	Wayne-Union
Sullivan, Robert E.	Ft. Wayne	Allen			
Sutton, Wm. E.	Indianapolis	Marion	Thompson, Wm. R.	Winamac	Pulaski
Suzuki, Tsutomu T.	Covington	Fountain-Warren	Thornburg, Kenneth	Indianapolis	Marion
			Thorne, C. E.	New Castle	Henry
Swan, John R.	Indianapolis	Marion	Thornton, Harold C.	Indianapolis	Marion
Swan, Richard Carl	Anderson	Madison	Thornton, Maurice J.	South Bend	St. Joseph
Swank, L. Forrest	Elkhart	Elkhart	Thornton, Walter E. (S)	Ft. Wayne	Allen
Sweet, Howard E.	Richmond	Wayne-Union	Thrasher, John R.	Indianapolis	Marion
Swihart, Homer R.	Elkhart	Elkhart	Thurston, H. S. (S)	Indianapolis	Marion
Swihart, L. F.	Elkhart	Elkhart	Tilden, Margaret	Evansville	Vanderburgh
Switzer, Robert E.	Bethesda, Md.	Noble	Tiley, George	Greenwood	Johnson
Symmes, Alfred T.	Indianapolis	Marion	Tilka, Edward	Hammond	Lake
Szokolay, Joseph P.	South Bend	St. Joseph	Tindal, E. F. (S)	Muncie	Delaware-Blackford
Szynal, John S.	Indianapolis	Marion			
<b>T</b>			Tindall, George T.	Indianapolis	Marion
Tager, Stephen	Evansville	Vanderburgh	Tindall, Paul R.	Shelbyville	Shelby
Take, J. F. (S)	French Lick	Orange	Tindall, Robert L.	Miami, Fla.	Marion
Talbert, Pierre C.	Bluffton	Wells	Tindall, Wm. R.	Shelbyville	Shelby
Talbott, Dan E.	Indianapolis	Marion	Tinney, W. E. (S)	Pass-A-Grille, Fla.	Marion
Tanner, Henry S.	Indianapolis	Marion			
Taube, Jack I.	Indianapolis	Marion	Tinsley, Frank W.	Indianapolis	Marion
Taylor, C. C.	Indianapolis	Marion	Tinsley, W. B.	Indianapolis	Marion
Taylor, E. C.	Upland	Grant	Tinsley, Walter B., Jr.	Indianapolis	Marion
Taylor, F. W.	Indianapolis	Marion	Tipler, Robert J.	Indianapolis	Marion
Taylor, Lon S.	Elberfeld	Warrick	Tipton, Wm. R.	Greencastle	Putnam
Taylor, W. H. (S)	Ambia	Benton	Tirman, Wallace S.	Bluffton	Wells
Taylor, W. R.	Richmond	Wayne-Union	Tischer, E. Paul	Indianapolis	Marion
Teague, Frank	Indianapolis	Marion	Titus, Charles (S)	Wilkinson	Hancock
Teal, Dorothy D.	Columbus	Bartholomew-Brown	Titus, Jack L.	Rensselaer	Jasper-Newton
Teegarden, J. A., Jr.	East Chicago	Lake	Tomak, Milton E.	Linton	Greene
Teegarden, J. A., Sr.	East Chicago	Lake	Tomlinson, C. H. (S)	Lake Bluff, Ill.	Hamilton
Teixler, V. A.	Indianapolis	Marion	Tondra, John M.	Indianapolis	Marion
Tempey, Fred W., Jr.	Westville	LaPorte	Toops, Thorndike C.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph	Topek, Nathan H.	Offutt, A.F.B., Neb.	Marion
Templin, D. B.	Lowell	Lake			
			Topolgus, James N.	Bloomington	Owen-Monroe



Name	City	County
Topping, M. C.	Terre Haute	Vigo
Torella, J. A.	Indianapolis	Marion
Tosick, William A.	Indianapolis	Marion
Toumey, Fred L.	Indianapolis	Marion
Tower, Thomas K.	Campbellsburg	Washington
Tracy, Julius R.	Anderson	Madison
Tranter, W. F.	Sharpsville	Tipton
Traver, P. C.	South Bend	St. Joseph
Travis, J. C., Jr.	Logansport	Cass
Tremain, M. A. (S)	Adams	Decatur
Treon, James F.	Aurora	Dearborn- Ohio
Trepagnier, Francis B.	East Chicago	Lake
Trinosky, Donald L.	Gary	Lake
Trinosky, Frank G.	Gary	Lake
Tripp, H. D.	Bloomington	Owen-Monroe
Trout, C. J.	Lafayette	Tippecanoe
Troutwine, William	Crown Point	Lake
Troy, Jack M.	Whiting	Lake
Truman, Elmer M., Jr.	Brookville	Fayette- Franklin
Trusler, H. M.	Indianapolis	Marion
Tubbs, George R. (S)	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, Leonard C.	Bainbridge, Ga.	Marion
Tucker, O. A.	Daleville	Delaware- Blackford
Tucker, Robert L.	Indianapolis	Marion
Tucker, Warren S.	Indianapolis	Marion
Tully, J. A. (S)	New Castle	Henry
Turgi, Robert W.	Gary	Lake
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson- Switzerland
Turner, H. B.	Bloomfield	Greene
Turner, Jack J.	Bloomfield	Greene
Turner, John P.	Goshen	Elkhart
Turner, Maurice A.	Oakland City	Gibson
Turner, Oscar A.	Madison	Jefferson- Switzerland
Turner, Robert	Muncie	Delaware- Blackford
Turrell, Eugene S.	Denver, Colo.	Marion
Tweedall, D. C.	Evansville	Vanderburgh
Tweedall, D. G.	Evansville	Vanderburgh
Tyler, F. T.	New Albany	Floyd
Tyner, Harlan H.	Indianapolis	Marion
Tyrrell, Joseph J.	Calumet City, Ill.	Lake
Tyrrell, Thomas C.	Calumet City, Ill.	Lake
U		
Uhrich, John H.	Monroeville	Allen
Ulrey, Robert P.	Indianapolis	Marion
Urschel, Dan L.	Mentone	Kosciusko
Utley, Marvan D.	Baltimore, Md.	Posey
Utterback, Arnold	Terre Haute	Vigo
V		
Vagner, Bernard	South Bend	St. Joseph
Vail, George A.	Lawrenceburg	Dearborn- Ohio
VanArsdall, C. R.	Terre Haute	Vigo
VanBokkelen, Robert	Mooreville	Morgan
Van Buskirk, E. L.	Lafayette	Tippecanoe
Vance, Wm. C.	Richmond	Wayne- Union
Van de Wertering, R.	Indianapolis	Marion
Van Den Bosch, W. R.	Westville	LaPorte
Vandevert, Arthur	Sellersburg	Clark
Vandivier, R. M.	Indianapolis	Marion
VanDorn, Myron J.	Indianapolis	Marion
VanFleet, Josephine	Indianapolis	Marion

Name	City	County
VanKirk, J. A.	Frankfort	Clinton
VanKirk, John R.	Burlington	Carroll
VanKirk, Paul P.	Frankfort	Clinton
VanMeter, C. Powell	Indianapolis	Marion
VanNess, William C.	Summitville	Madison
VanNest, W. A.	New Smyrna Beach, Fla.	Dekalb
VanNuys, John D.	Indianapolis	Marion
VanNuys, W. C. (S)	Indianapolis	Marion
VanOsdol, H. A.	Indianapolis	Marion
Van Rie, L. P.	Mishawaka	St. Joseph
Van Sandt, Frank A. (S)	Bloomfield	Greene
VanTassel, Charles J.	Indianapolis	Marion
VanVactor, Helen D.	Indianapolis	Marion
Van Wienen, John	Martinsville	Morgan
VanWinkle, Arthur J.	Valparaiso	Porter
Veach, Lester W.	Bainbridge	Putnam
Veach, Richard L.	Bainbridge	Putnam
Veazey, Wm. (S)	Avilla	Noble
Vellios, Frank	Indianapolis	Marion
Venable, George L.	N. Manchester	Wabash
Venis, Kemper N.	Muncie	Delaware- Blackford
Vermilya, R. W.	Lafayette	Tippecanoe
Verplank, G. L.	Gary	Lake
Viehe, Robert W.	Evansville	Vanderburgh
Vietzke, P. C. F.	Valparaiso	Porter
Vingis, Bronie	Greenfield	Hancock
Viney, Charles L.	Logansport	Cass
Visher, John W.	Evansville	Vanderburgh
Vivian, Donald E.	New Castle	Henry
Vlaskamp, Elaine	Muncie	Delaware- Blackford
Vogel, L. John	Mt. Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo
Voisinet, R. A.	Union City	Randolph
Vollrath, Victor J.	Indianapolis	Marion
VonAsch, George	LaPorte	LaPorte
Von de Leith, Wm. C.	Vincennes	Knox
Von Der Haar, Gerard	Indianapolis	Marion
Vore, Hugh A.	Highland	Lake
Vore, L. W.	Plymouth	Marshall
Vore, Robert E.	Indianapolis	Marion
Voyles, C. F. (S)	Indianapolis	Marion
Voyles, Harry	New Albany	Floyd
Vurpillat, Francis J.	South Bend	St. Joseph
Vye, James P.	Gary	Lake
W		
Wade, A. A.	Howe	LaGrange
Wagner, Arthur L.	Jasper	Dubois
Wagner, David G.	Goshen	Elkhart
Wagner, Richard	Huntington	Huntington
Wagoner, B. D.	Union City	Randolph
Wagoner, G. W.	Delphi	Carroll
Wagoner, John R.	Delphi	Carroll
Waite, Earl L. (S)	Macy	Miami
Waits, Chester L.	Colfax	Clinton
Waldo, J. Thayer	Indianapolis	Marion
Walerko, Frank	Mishawaka	St. Joseph
Walker, Adolph B.	Hammond	Lake
Walker, F. C.	Indianapolis	Marion
Walker, Floyd B.	Fort Wayne	Allen
Walker, Jack M.	Plainfield	Hendricks
Walker, J. L.	LaFontaine	Wabash
Walker, Robert K.	Indianapolis	Marion
Wall, Joseph A.	Wabash	Wabash
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Walters, Charles E.	Mishawaka	St. Joseph
Walters, Eleanore	Gary	Lake
Walters, William	Michigan City	LaPorte
Walther, Joseph E.	Indianapolis	Marion
Walton, William M.	Indianapolis	Marion
Waltz, Frank C.	Bicknell	Knox
Wanninger, Horace	Richmond	Wayne- Union
Ward, H. H. (S)	Coalmont	Clay

Name	City	County	Name	City	County
Ward, J. W.	New York, N.Y.	St. Joseph	White, Donald J.	Indianapolis	Marion
Ward, Jos. H.	Indianapolis	Marion	White, Harvey E.	Farmland	Randolph
Ward, Wesley C.	Indianapolis	Marion	White, I. D. (S)	Clinton	Parke- Vermillion
Warfel, F. C.	Indianapolis	Marion	White, James V.	Terre Haute	Vigo
Warfield, Chester H.	Ft. Wayne	Allen	White, John B.	Indianapolis	Marion
Warman, A. P.	Indianapolis	Marion	White, Philip T.	Indianapolis	Marion
Warn, William J.	Milan	Ripley	White, W. J. (S)	Gary	Lake
Warne, G. H.	Tipton	Tipton	Whitehead, John M.	Indianapolis	Marion
Warren, Frank R. (S)	Michigan City	LaPorte	Whitlock, Francis C.	Mishawaka	St. Joseph
Warren, Carroll B.	Marion	Grant	Whitlock, Merle E.	Mishawaka	St. Joseph
Warrick, Francis B.	Richmond	Wayne- Union	Whitsitt, S. A. (S)	Madison	Jefferson- Switzerland
Warrick, Homer L.	Osceola	St. Joseph	Wiatt, Leonard	Knightstown	Henry
Warriner, James B.	Indianapolis	Marion	Wicker, Eugene H.	Marion	Grant
Warvel, J. H.	Indianapolis	Marion	Wicks, O. C. (S)	Gary	Lake
Warvel, Joseph L. (S)	N. Manchester	Wabash	Wiedemann, F. E. (S)	Terre Haute	Vigo
Washburn, W. W.	Lafayette	Tippecanoe	Wierzalis, Edward F.	Hartford City	Delaware- Blackford
Washington, G. Kenneth	Gary	Lake	Wiethoff, Clifford Allen	Seymour	Jackson
Watson, James L.	Evansville	Vanderburgh	Wiggins, D. S. (S)	New Castle	Henry
Watterson, Gerald T.	Connersville	Fayette- Franklin	Wilcox, R. F.	LaPorte	LaPorte
Waymire, E. S.	Indianapolis	Marion	Wilber, Harold R.	Jeffersonville	Clark
Weaver, T. M. (S)	Brazil	Clay	Wilder, G. B.	Anderson	Madison
Weaver, Wm. W.	New Albany	Floyd	Wildman, R. E.	Peru	Miami
Weber, Edgar H.	Evansville	Vanderburgh	Wilhelm, Agatha M.	South Bend	St. Joseph
Weber, John R.	Ft. Wayne	Allen	Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Weber, Joseph G. S.	Terre Haute	Vigo	Wilhelmus, Charles M.	Newburgh	Warrick
Weber, Norbert	Fort Wayne	Allen	Wilhelmus, Gilbert	Evansville	Vanderburgh
Webster, Paul L.	Ligonier	Noble	Wilhelmus, Wm. M.	Evansville	Vanderburgh
Webster, R. K.	Brazil	Clay	Wilkins, I. W.	Indianapolis	Marion
Weddle, Chas. O.	Lebanon	Boone	Wilkerson, Edward L.	A.P.O. 42, New York	Vigo
Weeks, P. H.	Michigan City	LaPorte	Wilkins, R. W.	Ft. Wayne	Allen
Weems, M. P.	Jeffersonville	Clark	Wilkinson, Roger L.	Anderson	Madison
Wegner, William G. (S)	South Bend	St. Joseph	Willan, H. R.	Martinsville	Morgan
Wehrman, J. O. (S)	Indianapolis	Marion	Williams, A. H.	Ft. Wayne	Allen
Weigand, C. G.	Indianapolis	Marion	Williams, Alexander S.	Gary	Lake
Weil, H. J.	Indianapolis	Marion	Williams, Berniece	Ft. Wayne	Allen
Weinberg, B. A.	Whiting	Lake	Williams, Charles D.	Indianapolis	Marion
Weinberg, Samuel	Marion	Grant	Williams, Charles E.	Huntingburg	Dubois
Weinland, George C.	Indianapolis	Marion	Williams, C. L.	Indianapolis	Marion
Weinsoff, Beverly	Indianapolis	Marion	Williams, Edwin D.	Gary	Lake
Weinstein, E. B.	Richmond	Wayne- Union	Williams, Everett W.	Columbus	Bartholomew- Brown
Weinstock, Adolph	Rolling Prairie	LaPorte	Williams, F. M., Jr.	Anderson	Madison
Weir, Dale	LaGrange	LaGrange	Williams, F. P.	Huntingburg	Dubois
Weirich, Charles I.	Butler	Dekalb	Williams, Frederic N.	Mt. Vernon	Posey
Weiskopf, Henry S.	Gary	Lake	Williams, Gilbert E.	Milan	Ripley
Weiss, Eugene	South Bend	St. Joseph	Williams, H. J.	Morocco	Jasper- Newton
Weiss, H. G. (S)	Evansville	Vanderburgh	Williams, H. O.	Kendallville	Noble
Weiss, Jason	Indianapolis	Marion	Williams, H. S., Jr.	Indianapolis	Marion
Weitzel, Roland	Princeton	Gibson	Williams, Hugh L.	Indianapolis	Marion
Welborn, Mell B.	Evansville	Vanderburgh	Williams, John H.	Muncie	Delaware- Blackford
Welch, Norbert M.	Vincennes	Knox	Williams, John H.	Shipshewana	LaGrange
Weldy, Bryce P.	Hartford City	Delaware- Blackford	Williams, Paul D.	Indianapolis	Marion
Weller, Charles A.	Indianapolis	Marion	Williams, Robert D.	Markleville	Madison
Wellpott, Jean F.	Bloomington	Owen-Monroe	Williams, R. H.	Anderson	Madison
Welty, S. G.	Ft. Wayne	Allen	Willis, Charles F.	Evansville	Vanderburgh
Werry, L. E.	Hartford City	Delaware- Blackford	Willison, George	Evansville	Vanderburgh
Wertenberger, Morris D.	Richmond	Wayne- Union	Willner, Alan	Clarksville	Clark
West, Joseph L.	Indianapolis	Marion	Wills, Max	Auburn	DeKalb
Westfall, B. Kemper	Indianapolis	Marion	Willson, C. L.	Anderson	Madison
Westfall, George S.	Goshen	Elkhart	Wilmore, Ralph C.	Indianapolis	Marion
Westfall, John B.	Indianapolis	Marion	Wilson, David	Evansville	Vanderburgh
Westhaysen, Peter	Gary	Lake	Wilson, Douglas E.	Battle Creek, Mich.	Marion
Weyerbacher, A. F.	Indianapolis	Marion	Wilson, Fred	Terre Haute	Vigo
Whallon, Arthur J.	Richmond	Wayne- Union	Wilson, Fred M.	Indianapolis	Marion
Wharton, R. O.	Gary	Lake	Wilson, Guy	Bicknell	Knox
Whipps, Charles E.	Carlisle	Sullivan	Wilson, James	South Bend	St. Joseph
Whisler, F. M.	Wabash	Wabash	Wilson, John D.	Evansville	Vanderburgh
Whitcomb, Roger F.	Shelbyville	Shelby	Wilson, Leslie	Ft. Wayne	Allen
			Wilson, O. E.	Elkhart	Elkhart



Name	City	County	Name	City	County
Wilson, Oliver R.	Indianapolis	Marion	Wyeth, Charles (S)	Terre Haute	Vigo
Wilson, Paul	Boonville	Warrick	Wygant, M. D.	Mishawaka	St. Joseph
Wilson, P. H.	Logansport	Cass	Wyland, B. J.	Mishawaka	St. Joseph
Wilson, Ralph	Evansville	Vanderburgh	Winegar, David E.	Richmond	Wayne-Union
Wilson, Roland B.	Ft. Wayne	Allen	Wynn, J. F.	Evansville	Vanderburgh
Wilson, T. L.	Bloomington	Owen-Monroe	Wynne, R. E.	Bedford	Lawrence
Wimmer, Robert N.	Gary	Lake	Wytenbach, John E.	Indianapolis	Marion
Winter, Donald K.	Logansport	Cass		Y	
Winters, Matthew	Indianapolis	Marion	Yale, Charles A.	Winamac	Pulaski
Wise, Charles L.	Camden	Carroll	Yarling, J. E. (S)	Peru	Miami
Wise, Wm.	Indianapolis	Marion	Yarrington, C. W. (S)	Gary	Lake
Wise, William R.	Indianapolis	Marion	Yeck, Charles W.	Evansville	Vanderburgh
Wiseheart, O. H. (S)	North Salem	Hendricks	Yegerlehner, Roscoe	Kentland	Jasper-Newton
Wiseheart, Robert	Lebanon	Boone			
Wiseman, V. Earle	Greencastle	Putnam	Yencer, M. W. (S)	Richmond	Wayne-Union
Wisener, G. H.	Richmond	Wayne-Union			
Wishard, Wm. N., Jr.	Indianapolis	Marion	Yochem, August S., Jr.	Indianapolis	Marion
Wisniewski, Edward M.	Newtown, Conn.	Lake	Yocum, Paul S., Jr.	Gary	Lake
			Yocum, Paul S.	Gary	Lake
Wissman, William L.	Columbus	Bartholomew-Brown	Yocum, William S.	Gary	Lake
			Yoder, Albert C. (S)	Goshen	Elkhart
Witham, Robert L.	Indianapolis	Marion	Yoder, D. D.	Columbus	Bartholomew-Brown
Witt, William R.	Jeffersonville	Clark			
Wixted, John F.	Mishawaka	St. Joseph	Yoder, C. Richard	Elkhart	Elkhart
Wixted, Julia F.	Mishawaka	St. Joseph	Yoder, Jonathan G.	Goshen	Elkhart
Wohlfeld, Gerald	New Albany	Floyd	Yoder, Richard P.	Bluffton	Wells
Wohlfeld, J. B.	Bedford	Lawrence	York, Arthur F.	St. Paul, Minn.	Madison
Wojeik, Ladislav D.	Marion	Grant			
Wolfe, William E.	LaPorte	LaPorte	Younan, Tom	Boonville	Warrick
Wolfe, Nelson	New Albany	Floyd	Young, C. Curtis	Evansville	Vanderburgh
Wolfram, Don J.	Indianapolis	Marion	Young, G. M.	Gary	Lake
Wolverton, George M.	Clarks ville	Clark	Young, G. S.	Muncie	Delaware-Blackford
Wolaver, John H.	Louisville, Ky.	Vanderburgh			
Woner, John W.	Linton	Greene	Young, James W.	Indianapolis	Marion
Wood, Amelia T.	Muncie	Delaware-Blackford	Young, John E.	Indianapolis	Marion
			Young, John M.	Indianapolis	Marion
Wood, Donald E.	Indianapolis	Marion	Young, Ralph H.	Goshen	Elkhart
Wood, Elmer U. (S)	Columbus	Bartholomew-Brown	Young, Robert	Marion	Grant
			Young, Robert L.	Gary	Lake
Wood, Frederick H.	Bradenton, Fla.	Lake	Young, S. J. (S)	Kendallville	Noble
			Young, W. C.	Indianapolis	Marion
Wood, Opal L.	Brazil	Clay	Yunker, P. E.	Howe	LaGrange
Wood, R. W.	Oakland City	Gibson			
Woodard, Abram S., Jr.	Indianapolis	Marion		Z	
Woodbury, John W.	Marion	Grant	Zalac, Donald	Michigan City	LaPorte
Woodcock, C. E.	Greenwood	Johnson	Zallen, Stanley G.	East Chicago	Lake
Woods, A. L.	Poseyville	Posey	Zaring, B. K.	Columbus	Bartholomew-Brown
Woods, H. C.	Markle	Huntington			
Woods, James R.	Greenfield	Hancock	Zehr, Noah	Ft. Wayne	Allen
Woods, Wm. P. (S)	Evansville	Vanderburgh	Zeiger, Irvin	South Bend	St. Joseph
Woolery, R. H.	Bedford	Lawrence	Zell, Evertson H.	Indianapolis	Marion
Woolling, Kenneth R.	Indianapolis	Marion	Zeps, E. Frances	Evansville	Vanderburgh
Work, Bruce A.	Frankfort	Clinton	Zerfas, Charles P. A.	Indianapolis	Marion
Work, James A., Jr.	Elkhart	Elkhart	Zerfas, L. G.	Camby	Marion
Worley, A. C.	Ft. Wayne	Allen	Zerfas, Phyllis	Indianapolis	Marion
Worley, J. P.	Indianapolis	Marion	Zierer, R. O.	Anderson	Madison
Worley, Henry L.	New Albany	Floyd	Zimmer, Henry J.	Mishawaka	St. Joseph
Worley, Richard H.	Indianapolis	Marion	Zimmerman, Harold	Evansville	Vanderburgh
Worth, C. W.	Milroy	Rush	Zimmerman, Wm. H.	Dublin	Wayne-Union
Wright, Cecil S.	Anderson	Madison	Zink, Robert O.	Madison	Jefferson-Switzerland
Wright, J. Wm., Jr.	Indianapolis	Marion			
Wright, J. William	Indianapolis	Marion	Ziperman, H. Haskell	A.P.O. San Francisco, Calif.	Marion
Wright, W. C.	Ft. Wayne	Allen			
Wurster, H. C.	Mishawaka	St. Joseph	Zivich, John M.	East Chicago	Lake
Wyatt, Fred H.	Denver, Colorado	Vanderburgh	Zullo, Robert S.	Michigan City	LaPorte
			Zweig, E. S.	Ft. Wayne	Allen
			Zwerner, Paul F.	Terre Haute	Vigo
Wyatt, James L., II	Ft. Wayne	Allen	Zwick, Harold F.	Decatur	Adams
Wyatt, James L., III	Ft. Wayne	Allen	Zwickel, R. E.	Evansville	Vanderburgh



## ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid up members of the Indiana State Medical Association as of June 1, 1954)

### ADAMS COUNTY

Beaver, Norman ..... Berne  
Boze, Robert L. .... Berne  
Lehman, Harold ..... Berne  
Burk, James M. .... Decatur  
Carroll, John C. .... Decatur  
Girod, Arthur H. .... Decatur  
Kohne, Gerald J. .... Decatur  
Parrish, Richard K. .... Decatur  
Reppert, Roland L. .... Decatur  
Terveer, John B. .... Decatur  
Zwick, Harold F. .... Decatur  
Hinchman, Clarence P. .... Geneva  
Schetgen, Joseph V. .... Geneva

### ALLEN COUNTY

#### Fort Wayne

##### A

Aiken, Arthur F. .... 1923 E. State  
Aiken, Nevin E. .... 1923 E. State St.  
Arata, Justin E.  
702 Med. Center Bldg. (2)

##### B

Bailey, Paul P.  
206 Medical Center Bldg. (2)  
Baltes, Jos. H. .... 821 Broadway (2)  
Bash, Wallace E.  
2318 Fairfield Ave.  
Baumgartner, J. C.  
515 W. Wayne St. (2)  
Beams, Ralph  
715 Medical Center Bldg. (2)  
Beierlein, Karl M.  
334 Medical Center Bldg. (2)  
Benninghoff, D. R.  
208 Medical Center Bldg. (2)  
Bergendahl, Emil H.  
629 Medical Center Bldg. (2)  
Berghoff, R. J., 306 E. Jefferson (2)  
Beutler, Theodore V.  
527 W. Berry St.  
Bichacoff, Billie D.  
615 W. Wayne St. (2)  
Bickel, J. E. (S)  
2615 S. Lafayette (2)  
Blosser, H. V. (S) 309 W. Main (2)  
Bolman, Ralph M. .... 717 Broadway  
Bonner, Joseph N.  
310 E. Washington St.  
Borders, Theodore R.  
1145 S. Lafayette (2)  
Bowers, G. T. .... 307 E. Jefferson (2)  
Bowers, J. W. .... 418 Gettle Bldg.  
Bridges, William L.  
520 Medical Center Bldg. (2)  
Brosius, R. H. W. .... 1603 Wells (7)  
Brown, F. W.  
2301 Fairfield Ave. (6)  
Bruggeman, H. O.  
1202 Washington St. (2)  
Bryan, Franklin A.  
402 W. Washington Blvd.  
Buckner, Doster  
533 W. Washington St. (2)  
Buckner, George D.  
533 W. Washington St. (2)

##### C

Calvin, J. C. (S) 312 W. Wayne (2)  
Cameron, Don F.  
102 Medical Center Bldg. (2)  
Carey, Willis W. (S)  
2525 S. Calhoun (5)  
Carlo, E. R. .... 2902 Fairfield (6)  
Cartwright, E. L.  
230 Medical Center Bldg. (2)  
Chambers, A. R. 601 W. Wayne (2)  
Clark, W. R. .... 3622 S. Calhoun St.  
Cochran, Harry A., Jr.  
1301 S. Harrison  
Conley, J. E. .... 620 W. Berry (2)  
Cooney, C. J. .... 527 W. Berry (2)  
Cornell, B. S. .... 229 W. Berry St.  
Culp, J. E. .... 2902 Fairfield (6)

##### D

Dancer, C. R. (S)  
905 Columbia Ave.  
Datzman, Richard C.  
525 Medical Center Bldg. (2)  
Ditton, I. W. (S) 1214 E. Wayne (4)  
Duemling, A. H. 2902 Fairfield (6)  
Dunstone, H. C.  
502 Medical Center Bldg. (2)

##### E

Edlavitch, B. M. .... 716 Rockhill (2)  
Elston, Lynn W.  
622 Medical Center Bldg. (2)  
Elston, Ralph W.  
622 Medical Center Bldg. (2)  
Emenhiser, John L.  
R. 9, Maysville Rd.

##### F

Ferguson, Arthur N.  
2902 Fairfield Ave. (6)  
Fichman, A. M. .... 323 W. Berry (2)  
Foy, H. W. .... 1747 Wells St.

##### G

Garton, H. W. .... 1635 Broadway  
Gerding, W. J. .... 2638½ S. Calhoun  
Gladstone, N. H. .... 335 W. Berry (2)  
Glock, H. E. (S)  
324 Medical Center Bldg. (2)  
Glock, M. E. .... 312 W. Wayne (2)  
Glock, W. R. .... 2301 Fairfield Ave.  
Goebel, Carl W.  
2318 S. Fairfield Ave.  
Gould, L. K. .... 3415 S. Fairfield (6)  
Graham, George M.  
Lincoln Nat. Life Ins. Co.  
Greist, Walter D.  
3024 Fairfield Ave. (6)

##### H

Haffner, H. G. 202 E. Jefferson (2)  
Haller, Robert L.  
604 W. Wayne St.  
Hamilton, E. D.  
2405 Florida Dr. (3)  
Hamilton, Earl D.  
1536 S. Clinton St.  
Harshman, L. P.  
2704 N. Clinton (3)  
Harvey, H. C. .... 1202 E. State (3)  
Hasewinkle, A. M. 1129 E. State (3)  
Hastings, Warren C. 811 Ewing St.

Hattendorf, A. P.  
725 Medical Center Bldg. (2)  
Havens, R. E.  
312 Medical Center Bldg.  
Hiatt, Russell L. Veterans Hospital  
Hoffman, A. F. .... 233 E. Jefferson  
Hoffmann, S. P.  
234 E. Maple Grove St.  
Howe, F. L. .... 1525 Oxford St.

##### J-K

Jackson, John F. .... 414 W. Rudisill  
Johnston, Richard M.  
716 Medical Center Bldg. (2)  
Jurgensen, W. T. .... 3415 Fairfield  
Karol, Herbert J.  
624 Medical Center Bldg.  
Kaufman, Julian  
702 Medical Center Bldg.  
Keck, Carleton A.  
2902 Fairfield Ave. (2)  
Keller, Foster C.  
2154½ Fairfield Ave.  
Kent, Richard N.  
731 Medical Center Bldg. (2)  
Kidder, O. T. Irene Byron Hosp.  
Kimbrough, Robert F.  
618 Medical Center Bldg. (2)  
Kleifgen, William A.  
617 W. Washington St.  
Kruse, E. H. .... 705 Lincoln Tr. (2)  
Kruse, Walter E.  
512 Medical Center Bldg. (2)

##### L

Ladig, D. S. .... 337 E. Berry (2)  
Land, Francis L.  
116 W. Rudisill Blvd.  
Lehner, J. J.  
323 Medical Center Bldg. (2)  
Leming, Ben L.  
2902 Fairfield Ave.  
Lenk, G. G. .... 2007 Maumee (4)  
Lloyd, Robert P. .... 717 Broadway  
Lohman, R. M.  
229 Medical Center Bldg. (2)  
Lorman, James G.  
520 Medical Center Bldg. (2)  
Loudermilk, Jack L.  
525 Medical Center Bldg. (2)  
Lyon, William C.  
2902 Fairfield Ave. (6)

##### M

Mackel, Frederick O.  
2301 Fairfield Ave.  
Manning, George .... 811 Ewing St.  
McArdle, E. G. 2201 S. Calhoun (5)  
McCallister, John W.  
424 Medical Center Bldg. (2)  
McCoy, R. R. .... 3701 S. Harrison (6)  
McDowell, G. A.  
215 Medical Center Bldg. (2)  
McEachern, Cecil G.  
701 Medical Center Bldg. (2)  
McFall, J. R. S. .... 1706 Sherman  
McKeeman, Donald H.  
633 W. Wayne St. (2)  
McKeeman, L. S.  
304 Medical Center Bldg. (2)  
Marshall, C. L. .... 1207 S. Lafayette  
Mendenhall, Edgar  
208 Medical Center Bldg. (2)

## ALLEN COUNTY

## (Fort Wayne—Continued)

Mensch, James R.  
2506 Lower Huntington Road  
Mercer, Samuel R.  
710 Medical Center Bldg. (2)  
Meyer, H. A. . . . 1030 W. Wayne (2)  
Meyer, T. O.  
228 Medical Center Bldg.  
Michaelis, S. C. . . 2154 Fairfield (6)  
Miller, C. G. . . . 229 W. Wayne (2)  
Miller, H. Paul . . . 2809 Broadway  
Miller, Mahlon F.  
334 Medical Center Bldg. (2)  
Miller, O. J. . . . 324 W. Berry (2)  
Miller, R. H. . . . 511 W. Wayne (2)  
Miller, Robert B.  
714 Medical Center Bldg.  
Moats, C. F. . . . 4007 S. Wayne (6)  
Moats, G. E. 615 E. Washington St.  
Moeller, Victor C.  
4349 S. Anthony Blvd.  
Moravec, A. E. . . 705 Lincoln Tr. (2)  
Mortenson, L. J.  
214 Medical Center Bldg. (2)  
Mueller, L. W. . . . 533 W. Wash.  
Murdock, H. L.  
521 Medical Center Bldg. (2)

## N-O

Nahrwold, E. W.  
417 Medical Center Bldg. (2)  
Nill, J. H. . . . . 1024 S. Barr (2)  
O'Rourke, C. . . . 604 W. Berry (2)  
Oyer, J. H. . . . 2707½ S. Calhoun St.

## P

Painter, Donald S.  
222 Medical Center Bldg. (2)  
Parker, C. B. . . 1105 S. Harrison St.  
Perrin, K. F. . . 2701 S. Anthony St.  
Perry, F. G. . . . 2902 Fairfield (6)  
Pickett, Merle E.  
312 Medical Center Bldg. (2)  
Ponczek, Edward . . . 3926 Indiana  
Pontius Edwin E. 4724 Bowser Ave.  
Popp, Milton F.  
610 Medical Center Bldg. (2)

## Q-R

Rabson, S. M. . . 730 W. Berry St.  
Rawles, L. T. (S) 3131 Fairfield (6)  
Ray, Herbert A. (S)  
402 Medical Center Bldg. (2)  
Rice, W. B. . . . 1101 E. Pontiac (5)  
Rissing, W. J.  
416 Medical Center Bldg. (2)  
Rockey, N. A. . . 1224 E. State (3)  
Rodriguez, J. . . 2902 S. Fairfield (6)  
Roser, A. J. . . . 617 W. Washington  
Rossiter, D. L. . . 103½ E. Pontiac  
Rothberg, Maurice  
625 W. Berry St.  
Rothschild, C. J.  
319 Medical Center Bldg. (2)

## S

Sahlmann, H. . . 1320 Broadway (2)  
Salon, H. W. . . . 535 W. Berry (2)  
Salon, Joel W. . . 604 W. Wayne St.  
Salon, Nathan L. . 604 W. Wayne  
Sarver, Francis E.  
304 Medical Center Bldg. (2)  
Savage, A. R. . . . 302 W. Berry (2)

Schellhouse, Earl. . . 1240 W. Main  
Schlademan, Karl R.  
516 Medical Center Bldg. (2)  
Schlegel, Edward H.  
1022 University St.  
Schmidt, Eugene E.  
312 Medical Center Bldg. (2)  
Schmoll, R. J. . . . 604 W. Berry St.  
Schneider, L. H. . . 730 W. Berry St.  
Schoen, Frederic L.  
604 W. Wayne St.  
Scoins, W. H. . . . 1301 S. Harrison  
Scott, H. V. . . . 2902 Fairfield (6)  
Senseny, Eugene F.  
116 W. Rudisell Blvd.  
Senseny, Herbert  
314 Medical Center Bldg. (2)  
Sherwood, Clarence E.  
Irene Byron Hosp.  
Sherwood, J. V.  
Irene Byron Hosp.  
Shinabery, L. . . . 1850 Broadway (6)  
Short, J. T. . . . 2902 Fairfield (6)  
Singer, Elmer C.  
825 Oakdale Dr.

Smith, Philip L.  
2902 Fairfield (6)  
Snyderman, Sanford C.  
629 Medical Center Bldg. (2)  
Somers, Gerald H.  
2506 Lower Huntington Rd. (8)  
Stauffer, R. C.  
618 Medical Center Bldg. (2)  
Stellner, H. . . . 324 W. Berry St.  
Stier, Paul L. . . . 721 Broadway  
Sullivan, Robert E.  
102 Medical Center Bldg. (2)

## T

Tennant, David L. 1832 S. Calhoun  
Terrill, R. W. . . 455 Lincoln Tr. (2)  
Theye, Richard A.  
312 Medical Center Bldg. (2)  
Thimlar, J. W. . . 602 E. Lewis (2)  
Thompson, H. . . Irene Byron Hosp.  
Thornton, Walter E. (S)  
Lincoln Nat. Life Ins. Co.

## W

Walker, Floyd B. . 610 E. Pontiac  
Warfield, C. H. . . 730 W. Berry St.  
Weber, John R.  
519 Medical Center Bldg.  
Weber, Norbert  
233 E. Jefferson St.  
Welty, S. G. 2702½ S. Calhoun (5)  
Wilkins, R. W. . . 2902 Fairfield (6)  
Williams, A. B. 3526 N. Wash. Rd.  
Williams, A. H. . . 2902 Fairfield (6)  
Wilson, Leslie . . . Veterans Hosp.  
Wilson, R. B. 1207 S. Lafayette (2)  
Worley, Ansel C.  
317 Medical Center Bldg. (2)  
Wright, Wm. C.  
621 Medical Center Bldg. (2)  
Wyatt, James L. III  
336 W. Berry St.  
Wyatt, J. L. II. 233 E. Jefferson (2)

## X-Y-Z

Zehr, Noah . . . 301 W. Creighton (6)  
Zweig, E. S. . . . 344 W. Berry (2)  
Emme, Richard W. . . . Harlan  
Cutshaw, James A. . . . Monroeville  
Harless, Fred. . . . . Monroeville

Dahling, C. W. . . . New Haven  
Hoetzer, Eldore M. . . New Haven  
Smith, Grover A. . . . New Haven  
Smith, Richard B. . . . New Haven  
Stumpf, Edwin E. . . . New Haven  
Emenhiser, Donald C.  
R. R. 2, Woodburn  
Moser, Edward (S)  
Box 65, Woodburn  
Draper, Merlin H. . . 59 Dolphin Dr.,  
St. Petersburg, Fla.  
Havice, Jay F.  
Box 56, Lake Lure, N. C.  
Prentiss, Nelson H.  
V.A. Hosp., Otenne, N. C.  
Schafer, Donald W.  
807 Frazier, Topeka, Kan.

BARTHOLOMEW-BROWN  
COUNTIES

## Columbus

Adler, David L.  
Bartholomew County Hospital  
Beggs, Lowell F.  
633 Washington St.  
Davis, Marvin R.  
814 Washington St.  
Echsnor, Herman J. . . 1813 25th St.  
Fisher, Walter S. . . . 422 9th St.  
Hart, Robert B.  
712 Washington St.  
Hawes, James K. (S)  
725 Washington St.  
Hawes, Marvin E.  
633 Washington St.  
Henry, Alvin L. . . 621 Franklin St.  
Krueger, Robert B.  
814 Washington St.  
Macy, George W.  
718 Washington St.  
Marr, Griffith . . 741 Washington St.  
McCullough, Henry G. . . Columbus  
Mohler, Floyd W. . . . Columbus  
Norton, Harold J.  
911 Washington St.  
O'Bryan, Richard B. 326 16th St.  
Overshiner, Lyman  
633 Washington St.  
Reid, Robert M.  
725 Washington St.  
Ritteman, George W.  
Bartholomew County Hospital  
Rothring, Howard E.  
Bartholomew County Hospital  
Ryan, William J.  
911 Washington St.  
Schmitt, Richard K. . 423 Ninth St.  
Sigmund, William B. . 522 7th St.  
Smith, Don C. 911 Washington St.  
Teal, Dorothy Denzle  
728 Franklin St.  
Williams, Everett W.  
725 Washington St.  
Wissman, William L.  
725 Washington St.  
Wood, Elmer U. (S)  
2012 Washington St.  
Yoder, Dewey D.  
725 Washington St.  
Zaring, Byron K.  
718 Washington St.

Dudding, Joseph E. . . . Hope  
Schneider, Kenneth . . . Nashville



**BENTON COUNTY**

Taylor, Wade H. (S).....Ambia  
 Atkinson, Charles W. (S)....Boswell  
 Leak, Robert.....Boswell  
 Coddens, A. L.....Earl Park  
 Altier, William H.....Fowler  
 Miller, Dan T.....Fowler  
 Turley, Verne L.....Fowler  
 McCabe, James E. (S).....Otterbein  
 Rutherford, Charles E.....Otterbein  
 Smith, Charles G.....Otterbein  
 Scheurich, Virgil.....Oxford

**BLACKFORD COUNTY**

(See Delaware-Blackford)

**BOONE COUNTY**

Riley, Frank H. (S).....Jamestown  
 Schaaf, Alvin D.....Jamestown

**Lebanon**

Beck, Herma A.  
 Pioneer Equitable Bldg.  
 Coons, John D.

Pioneer Equitable Bldg.

Coons, Ritchie.....Lebanon  
 Headley, Lloyd M. 205 S. East St.  
 Honan, Paul R. 820 N. East St.  
 Kern, Clarence G. 423 E. Main St.  
 Porter, Jack 209 W. North St.  
 Rainey, Everett A. (S)

Pioneer Equitable Bldg.

Spieth, William H.

303 N. Lebanon St.

Weddle, Charles O.

905 N. Lebanon St.

Wiseheart, Robert H.

905 N. Lebanon St.

Bassett, Clancy (S).....Thorntown

Bassett, Margaret A.....Thorntown

Gregg, Edwin E.....Thorntown

Bailey, Lawrence S.....Zionsville

Harvey, Ralph J.....Zionsville

Lovett, Harvey.....Whitestown

**BROWN COUNTY**

(See Bartholomew-Brown)

**CARROLL COUNTY**

VanKirk, John R.....Burlington  
 Kennedy, Eva N.....Camden  
 Wise, Charles L.....Camden  
 Byrne, John M.....Delphi  
 Crampton, Charles C. (S).....Delphi  
 Seese, Robert M.....Delphi  
 Wagoner, George W.....Delphi  
 Wagoner, John R.....Delphi  
 Adams, Max R.....Flora  
 McLaughlin, James R.....Flora

**CASS COUNTY**

Dutchess, C. Toney.....Galveston

**Logansport**

Adamski, Michael....408 North St.  
 Bailey, Earl W.....212 Fifth St.  
 Ballard, Chas. A....325½ E. Market  
 Cooper, Thomas L....408 North St.  
 Davis, John C.....Masonic Temple  
 Ferguson, John T....State Hosp.  
 Fitzgerald, Brice E.

Masonic Temple

Grant, John H.....State Hosp.

Hall, Bernard R.....415 North St.

Hedde, Eugene L....309 Seventh St.

Hillis, Lowell J.....203 S. Third

Hochhalter, M....307 Barnes Bldg.  
 Hogle, F. D....Logansport St. Hosp.  
 Holloway, W. A. (S)

200 Eel River Ave.

Jewell, Earl B....3019 S. Penn St.

Jones, J. Carl.....422 North St.

Killian, E. Camille

211 S. Third St.

Larson, John A.....State Hosp.

Lemon, H. K.....State Hosp.

Maschmeyer, Robert H.

State Hosp.

Maxwell, John B. (S)

1119 High St.

Morrical, Russell S....212 Fifth St.

Morrow, George W....State Hosp.

Pfuetze, Max.....State Hosp.

Schenk, Foss.....97 21st St.

Shultz, Henry M. (S)

412 Fourth St.

Slimp, Thomas E....216 Ninth St.

Stanton, Jas. J....220 S. Sixth St.

Stewart, Milton B. (S)

1515 E. Broadway

Terfinger, Fred W. (S)

422 North St.

Travis, Julius C.....State Hosp.

Viney, Charles L....Masonic Temple

Wilson, Paul H....422 North St.

Winter, Donald K....422 North St.

Newcomb, Wm. K....Royal Center

Flanagan, Estle P.....Walton

Lybrook, Daniel E. Young America

Landis, Charles

808 Junior Terrace,

Chicago, Ill.

**CLARK COUNTY**

Bottorff, David.....Charlestown

Buckman, Robert J....Charlestown

Duffield, John R....Charlestown

Eckles, Donald H....Charlestown

Goodman, Eli.....Charlestown

Patterson, Cecil.....Charlestown

Ruoff, William.....Clarksville

Willner, Alan.....Clarksville

Wolverton, George M. Clarksville

Greene, William R....Henryville

**Jeffersonville**

Adair, Samuel L. 201 E. Market St.

Baldwin, J. H. (S) 425 Meigs Ave.

Bruner, Ralph W....437 Spring St.

Buckley, Ernest P.

14 Blanchel Terrace

Buehler, George M....437 Wall St.

Carlberg, Dale.....442 Spring St.

Carney, Joel T....344 Spring St.

Clark, William B., Jr.

205 Lindley Bldg.

Dare, Lee A....209 E. Maple St.

Forsee, Norman E....456 Spring St.

Havens, A. Lyle 205 Lindley Bldg.

Huoni, John S....105 W. Maple St.

Isler, Nathaniel C....521 Spring St.

Reeder, Henry H....140 High St.

Roby, A. L.....201 E. Market

Weems, Mallory P.

203 Lindley Bldg.

Wilber, Harold....437 Spring St.

Witt, William R.....Pfifer Bldg.

Regan, George L.....Sellersburg

Sturgis, D. G.....Sellersburg

Vandervert, Arthur C. Sellersburg

Bizer, Mier A.

Christ Hosp., Cincinnati, O.

**CLAY COUNTY****Brazil**

Maurer, J. Frank

111 N. Walnut St.

Maurer, Robert M.

111 N. Walnut St.

Mehne, Richard G.

1½ E. National Ave.

Palm, John M....Brazil Trust Bldg.

Shattuck, John C.

1½ E. National Ave.

Weaver, Timothy M. (S)

Brazil Trust Bldg.

Webster, Robert K.

Brazil Trust Bldg.

Wood, Opal L. 111 N. Walnut St.

Moon, Charles E....Center Point

Bond, Walter C.....Clay City

Glosson, Jack R.....Clay City

Muncie, Henry L. (S) Cloverland

Ward, Harry H. (S) Coalmont

**CLINTON COUNTY****Frankfort**

Waits, Chester L.....Colfax

Applegate, A. E....51 E. Walnut St.

Beardsley, Frank A.

51 S. Jackson St.

Beardsley, John 51 S. Jackson St.

Burroughs, Carroll A.

59 S. Main St.

Carrel, Francis E.

207½ N. Jackson St.

Dykhuizen, Theodore A.

59 S. Main St.

Erdel, Milton W....59 S. Main St.

Hammersley, Geo. K.

361 E. Clinton St.

Hedgcock, Robert A.

205 E. Clinton St.

Holmes, Claude, Sr. 9½ W. Clinton

Jones, William W.

9½ W. Clinton St.

Kneidel John H.

Clinton County Hospital

Stout, Harry T., Jr.

361 E. Clinton St.

Van Kirk, John A.

204 W. Washington St.

Van Kirk, Paul P.

204 W. Washington St.

Work, Bruce A. 47½ S. Jackson St.

Ballard, Robert J.....Kirklin

Carlyle, Ivan E....Michigantown

Combs, Nelson B.....Mulberry

Grove, Robert H.....Rossville

Ketcham, John S.....Rossville

Compton, Charles B.

4251 7th Ave., Los Angeles, Cal.

**CRAWFORD COUNTY**

(See Harrison-Crawford)

**DAVIESS-MARTIN COUNTIES**

Rohrer, James R.....Elnora

Chattin, Robert E.....Loogootee

Gootee, Francis H.....Loogootee

Lett, Emory B.....Loogootee

McCracken, Jacob O. (S)

Montgomery

Sears, Don.....Odon

Coleman, H. G.....Odon

Gilkinson, William L. (S) Shoals



**Washington**

Arthur, Nora M. (S).....R. R. 4  
Blazey, Arthur G. Williams Bldg.  
Burruss, Bert O. (S)

State Bank Bldg.

Chattin, Vance J. 514 E. Main St.  
Farris, John J. 514 E. Main St.  
Fox, C. Philip

305 Peoples Bank Bldg.  
Lindsay, Hamlin B.

511 East Main St.  
Lloyd, Claude A. 107 N.E. 2nd St.  
McKittrick, Jack

Peoples Bank Bldg.  
McNaughton, L. M.

400 E. Hefron St.  
Norton, Horace. 511 E. Hefron St.  
Rang, Arthur A. 211 N.E. 9th St.  
Rang, Robert H. 211 N.E. 9th St.  
Schafer, Wm. C. 1312 Bedford Rd.  
Seat, Marshall H.

101 N. E. 1st St.  
Shields, Harry A. 106 E. Main St.  
Smoot, Emory B. 507 E. Main St.  
Schroeder, Henry R.

St. Joseph Infirmary,  
Louisville, Ky.

**DEARBORN-OHIO  
COUNTIES**

Baker, Leslie M. .... Aurora  
Jackson, John K. .... Aurora  
Olcott, Charles W. .... Aurora  
Stewart, Omer H. .... Aurora  
Treon, James F. .... Aurora  
McNeely, Matthew J. .... Dillsboro  
Elliott, John C. .... Guilford  
Fagaly, William J. .... Lawrenceburg  
Houston, Fred D. .... Lawrenceburg  
Pfeifer, James M. .... Lawrenceburg  
Streck, Francis A. .... Lawrenceburg  
Vail, George A. .... Lawrenceburg  
Fessler, Gordon S. .... Rising Sun  
Manley, Charles N. .... Rising Sun

**DECATUR COUNTY**

Tremain, Milton A. (S)....Adams

**Greensburg**

Acher, Robert P.  
216 E. Washington St.  
Blemker, Russell H.

N. Franklin St.  
Callaghan, Winship C.

Union Trust Bldg.  
Dickson, Dale D. 420 E. Main St.  
Miller, James C.

178 N. Michigan Ave.  
Morrison, James T.

207 N. Franklin  
Overpeck, Charles. Dalmbert Bldg.  
Sallee, William T. .... Bates Bldg.  
Shaffer, William R. .... Taylor Bldg.  
Harkcom, Harry E. .... St. Paul  
Porter, Robert A. .... Westport

**DEKALB COUNTY**

Covell, Harry M. .... Auburn  
Hines, Archie V. .... Auburn  
Hippensteel, Harold V. .... Auburn  
Nugen, Harold .... Auburn  
Rogers, Evered E. .... Auburn  
Sanders, Jesse A. .... Auburn  
Souder, Bonnell M. .... Auburn  
Wills, Max .... Auburn  
DeVoe, Kenneth. .... Butler  
Hathaway, Clayton B. .... Butler  
Weirich, Charles I. .... Butler

Jinnings, Loren E. .... Garrett  
Kantzer, Floyd B. .... Garrett  
Nason, Robert A. .... Garrett  
Novy, Charles A. .... Garrett  
Reynolds, D. Monroe (S) .. Garrett  
Reynolds, Russell P. .... Garrett  
Coleman, Floyd B. .... Waterloo  
Showalter, John P. .... Waterloo  
Van Nest, Willard A.  
New Smyrna Beach, Fla.

**DELAWARE-BLACKFORD  
COUNTIES**

Brown, Stewart D. .... Albany  
Puterbaugh, Karl E. .... Albany  
Hurley, John R. .... Daleville  
Tucker, Oral A. .... Daleville  
Ko, Richard .... Eaton  
Downard, Leland F. .... Gaston  
Langsdon, Fred R. .... Gaston  
Dando, G. H. (S) .. Hartford City  
Dodds, Jas. U. .... Hartford City  
Jackson, Dean B. .... Hartford City  
Owsley, Guy A. .... Hartford City  
Weldy, Bryce P. .... Hartford City  
Werry, Leslie E. .... Hartford City  
Wierzalis, Edward F.

Hartford City  
Burns, Paul E. .... Montpelier  
Douglas, William T. .... Montpelier

**Muncie**

Adams, W. B. .... Ball Mem. Hosp.  
Alvey, C. R.

402 W. Washington St.  
Ball, Clay A. .... 303 W. Adams  
Ball, Phillip

420 W. Washington St.  
Bibler, Henry E. .... 311 W. Adams  
Botkin, C. G. .... 508 W. Jackson  
Botkin, Thos. .... 417 N. Martin St.  
Brown, Leland G.

206 S. High St.  
Brown, Thomas M.

206 S. High St.  
Brunoehler, Carl J.

403 N. High St.  
Bryan, Theodore L.

420 W. Washington St.  
Burwell, Stanley W.

424 W. Jackson St.  
Butterfield, R. M. .... 315 W. Jackson  
Clauser, E. H. M. .... 315 S. Jefferson  
Clevenger, J. H. .... 424 W. Jackson  
Covalt, W. E. .... 305 West. Res. Bldg.  
Cure, E. T. .... 105 West. Res. Bldg.  
Davis, Edgar C. .... 107 Plaza Bldg.  
Deutsch, Wm. .... 309 Johnson Bldg.  
Dunn, F. W. .... 118 S. Franklin  
Franklin, John W.

420 W. Washington St.  
Funk, John W. .... 217 W. Charles  
Galliher, M. J. .... 115 S. Liberty  
Garling, L. C. .... 420 W. Washington  
Geckler, Charles E.

Muncie Clinical Lab.  
Gill, Thos. A. .... 808 W. Jackson  
Greiber, M. F. .... 420 W. Washington  
Gustafson, Milton. .... 808 W. Jackson  
Hall, Orville A. .... 514 Wysor Bldg.  
Hayes, T. R. .... 210 S. High  
Henderson, R. A. .... 806 W. Main  
High, Ralph L. .... 420 W. Washington  
Hill, Howard E. .... 402 W. Jackson  
Hill, Robert E. .... 215 W. Jackson  
Hostetter, Irwin S. .... 115 N. Cherry  
Hurley, Anson G. .... 110 N. Cherry

Imhof, Jos. D. 206 West. Res. Bldg.  
Kammer, G. C. 420 W. Washington  
Kammer, W. F. 420 W. Washington  
Kemper, A. T. (S) .. 112 W. Adams  
Kern, C. B. (S) ..... 31 Mann  
Kirshman, F. E. .... 211 S. High  
Kuder, Howard V.

420 W. Washington  
LaDuron, J. F. .... 517 S. Liberty  
McClintock, James A.

316 W. Adams  
McCoy, George E. 417 Wysor Bldg.  
McDowell, Fletcher W.

315 S. Jefferson  
Molloy, W. J. (S)

619 E. Charles St.  
Montgomery, Lall G.

Ball Memorial Hospital  
Moore, Wm. C. .... 110 N. Cherry  
Morris, Jean W. 247 Johnson Bldg.  
Nelson, Harold E.

Ball Memorial Hospital  
Owens, R. R. .... 406 West. Res. Bldg.  
Owens, T. R. .... 202 West. Res. Bldg.  
Peacock, Robert C.

205 West. Res. Bldg.  
Quick, Wm. J. .... 314 E. Washington  
Rathkey, Arthur S.

420 W. Washington St.  
Rettig, Arthur C. .... 314 W. Jackson  
Rivers, Glynn A. .... 806 W. Jackson  
Saperstein, Morris

2327 S. Madison St.  
Schulhof, M. G. .... 420 W. Wash.  
Silver, Richard A. Ball Mem. Hosp.  
Smith, Jas. S. .... 501 Kirby  
Spurgeon, O. E. (S)

310 E. Washington  
Stanley, John R.

310 W. Jackson St.  
Starks, William O.

420 W. Washington St.  
Stocking, B. W. .... Ball Mem. Hosp.  
Stout, Francis E.

303 Western Res. Bldg.  
Tindal, E. F. (S) 214 Wysor Bldg.  
Turner, Robt. D. .... 217 S. Liberty  
Venis, K. N. .... 108 N. Liberty  
Vlaskamp, E. M. .... 401 W. Main  
Williams, J. H. .... 306 E. Jackson  
Wood, Amelia T. .... 2004 Petty Rd.  
Young, G. S. .... 316 W. Jackson

Moss, Mavor J. .... Yorktown  
Mahuron, Boyd L.

Miami Valley Hospital,  
Dayton 9, Ohio

**DUBOIS COUNTY**

Backer, Henry G. .... Ferdinand  
Amini, Sohrab. .... Huntingburg  
Bretz, John M. .... Huntingburg  
Lukemeyer, L. C. (S)

Huntingburg  
Steinkamp, Emil F. .... Huntingburg  
Stork, Harvey K. .... Huntingburg  
Williams, Charles E. .... Huntingburg  
Williams, F. P. .... Huntingburg  
Blessinger, Paul J. .... Jasper  
Gootee, Thomas H. .... Jasper  
Greenburg, Rolland .... Jasper  
Heck, Martin C. .... Jasper  
Held, George A. .... Jasper  
Klamer, Charles H. .... Jasper  
Lukemeyer, St. John. .... Jasper  
Ploetner, Edward J. .... Jasper  
Salb, Leo A. .... Jasper  
Wagner, Arthur L. .... Jasper



**ELKHART COUNTY**

Horswell, Richard G. . . . . Bristol  
Neidballa, Edward G. . . . . Bristol

**Elkhart**

Arlook, Theo. D. . . . . 912 W. Franklin  
Bender, Robt. L. . . . . 411 S. Third  
Billings, Elmer R. . . . . 115 S. Third St.  
Bloom, Geo. R. . . . . 506 S. Second  
Bolin, Robt. S. . . . . 209 S. Second  
Bowdoin, Geo. E. . . . . 515 S. Second  
Compton, W. A. . . . . 2225 Greenleaf  
Conklin, R. L. . . . . 1906 E. Jackson  
Cormican, H. L. . . . . 316 S. Fourth  
Crandall, L. A. . . . . Ames Laboratories  
DeDario, L. M. . . . . 123 W. Marion  
Dovey, Edward G. . . . .

405 S. Second St.

Elliott, Lloyd A. . . . . 405 S. Second  
Elliott, Thomas A. . . . .

405 S. Second St.

Fleming, C. F. . . . . 121 W. Marion  
Fleming, Justus M. . . . . 123 W. Marion  
Futterknecht, James O. . . . .

405 S. Second St.

Hull, Arthur W. . . . . 506 S. Second  
Ivy, John H. . . . . 405 S. Second St.  
Kintner, B. E. . . . . 132 Monger Bldg.  
Kistner, A. W. . . . . 123 W. Marion  
Koehler, Elmer G. . . . . Monger Bldg.  
Leasure, Kenneth . . . . .

903 W. Franklin St.

Lehman, Waldo J. . . . . 411 S. Third St.  
Logan, Richard S. . . . . Monger Bldg.  
Lundt, Milo O. . . . . 521 S. Second  
Markel, Ivan J. . . . . 215 W. Franklin  
McArt, Bruce A. . . . . 209 Equity Bldg.  
McKee, H. N. (S) . . . . .

319 Monger Bldg.

Mendez, Carlos . . . . . 116 W. Marion  
Miller, H. A., Jr. . . . . 314 W. Jackson  
Miller, Samuel T. . . . . 506 S. Second  
Mininger, E. P. . . . . 413 W. Franklin  
Mishkin, Irving . . . . . 209 S. Second  
Norris, Allen A. (S) . . . . .

208 W. Marion

Paff, Wm. A. . . . . 515 S. Second  
Paine, Geo. E. . . . . 329 Meisner Ave.  
Pancost, V. K. . . . . 415 S. Second  
Patrick, Glenn B. . . . . 427 S. Second  
Rohr, Joseph H. . . . .

Ames Laboratories

Rouen, Robert . . . . . Monger Bldg.  
Rupe, Lloyd O. . . . . Equity Bldg.  
Schlosser, H. C. . . . . 116 W. Marion  
Sears, M. M. (S) . . . . . 304 Equity Bldg.  
Spray, Page E. . . . . 316 4th St.  
Stauffer, W. A. (S) . . . . .

214 Equity Bldg.

Stout, R. B. . . . . 1501 Greenleaf Blvd.  
Stubbins, Wm. M. . . . . 412 S. Second  
Swank, L. F. . . . . 315 Equity Bldg.  
Swihart, H. R. . . . . 124 W. Marion St.  
Swihart, L. F. . . . . 214 W. Marion  
Wilson, O. E. . . . . 217 N. Main  
Work, Jas. A., Jr. . . . . 412 S. Second  
Yoder, C. Richard . . . . .

413½ W. Franklin

**Goshen**

Amstutz, H. C. . . . . 521 S. Main  
Bartholomew, M. L. . . . . 107 S. Fifth  
Bender, C. K. . . . . 115 E. Washington  
Bigler, Frederick W. . . . .

314 S. 5th St.

Bosler, Howard A. . . . .

Waterford Mills, Mail Goshen  
Chandler, Leon H. . . . . 412 S. 5th St.

Eby, Ida L. . . . . 131 S. Main  
Freeman, F. M. . . . . 109 W. Wash.  
Hostetler, C. M. . . . . 304 E. Lincoln  
Kelly, Wm. R. . . . . 210 N. Main  
Martin, Floyd S. . . . . 127 E. Lincoln  
Miller, M. E. . . . . Spohn Bldg.  
Simmons, L. H. . . . . 208 E. Lincoln  
Turner, John P. . . . . Shoots Bldg.  
Wagner, David G. . . . . 307 S. 7th St.  
Westfall, Geo. S. . . . . 214 E. Lincoln  
Yoder, Albert C. (S) . . . . . 113 S. Fifth  
Yoder, Jonathan G. . . . .

314 E. Lincoln Ave.

Young, Ralph H. . . . . 113 E. Madison

Massanari, Walter . . . . . Millersburg  
Norris, Ernest B. . . . . Middlebury  
Teters, Melvin S. . . . . Middlebury  
Fleetwood, R. A. . . . . Nappanee  
Kendall, Forest M. . . . . Nappanee  
Price, Douglas W. . . . . Nappanee  
Slabaugh, Jancy S. (S) . . . . . Nappanee  
Roose, Lisle W. . . . . Nappanee  
De Fries, John . . . . . New Paris  
Abel, Robert . . . . . Wakarusa  
Amick, Charles L. . . . . Wakarusa  
Hannah, Jack W. . . . . Wakarusa  
Dewey, Fred N. (S) . . . . .

1216 River Rd., Maumee, Ohio

Miller, Galen R. . . . .

V.A. Hosp., Minot, N. D.

**FAYETTE-FRANKLIN COUNTIES**

Foreman, Walter A. . . . . Brookville  
Peters, Elmer . . . . . Brookville  
Seal, Perry F. . . . . Brookville  
Smith, Herbert N. . . . . Brookville  
Truman, Michael . . . . . Brookville

**Connersville**

Dale, Maxwell H. . . . . 818 Grand  
Ellis, Geo. M., Jr. . . . . 108 E. Tenth  
Entner, Charles L. . . . . 117 E. Sixth  
Fruth, Rodney B. . . . . 634 Eastern  
Fruth, Virgil J. . . . . 634 Eastern  
Gregg, Albert F. . . . . 124 E. Sixth  
Hudson, Arlington M. . . . . 716 Grand  
Kemp, William A. . . . . 122 W. Seventh  
Kerrigan, William F. . . . . 718 Central  
Lockhart, Jack M. . . . . 520 Eastern  
Mountain, Francis B. . . . . 930 Central  
Neukamp, Frank H. . . . .

621½ Central Ave.

Smelser, Herman W. . . . . 823 Central

Steinem, Joseph L. . . . .

523½ Central Ave.

Watterson, Gerald T. . . . .

1910 Virginia Ave.

Phillips, William R. (S) . . . . . Glenwood  
Poston, C. L. . . . . R. R. 2, Laurel

**FLOYD COUNTY**

Engleman, Harry K. (S) . . . . .

Georgetown

**New Albany**

Allen, Frederick K. . . . .

1207 E. Spring St.

Baker, Avey M. . . . . 811 E. Spring  
Baxter, Jas. W. . . . . 1201 E. Spring  
Baxter, Saml. M. . . . . 1201 E. Spring  
Briscoe, C. E. (S) . . . . . 1413 E. Spring  
Brown, Kenneth H. . . . . 410 E. Spring  
Byrn, Howard W. . . . . 415 Elsby Bldg.  
Davis, Parvin M. . . . . 601 E. Spring

Edwards, William F. . . . .

Floyd County Bank Bldg.

Garner, William H., Jr. . . . .

919 E. Spring St.

Garner, Wm. H. . . . . 919 E. Spring

Gentile, John P. . . . . 101 Adams St.

Hauss, A. P. . . . . 212 Elsby Bldg.

Hess, Paul P. . . . .

Floyd Co. Bank Bldg.

Higgins, John R. . . . .

624 E. Spring St.

LaFollette, Robt. E. . . . . 500 E. Spring

LaFollette, Don. . . . . 500 E. Spring St.

McCullough, J. Y. . . . . 624 E. Spring

Murphy, Edgar W. . . . . 1824 State

Pace, Jerome V. . . . . Silvercrest San.

Paris, John M. . . . . 602 E. Spring

Pierce, Gene S. . . . . R. R. 21

Polhemus, G. I. . . . . 1610 E. Spring

Robertson, A. N. . . . . 820 E. Spring

Roggkamp, Milton W. . . . .

1516 State St.

Sloan, Herbert . . . . . 1207 E. Spring

Streepey, J. I. . . . . 1102 E. Spring

Tyler, Frank T. . . . . 420 Vincennes

Voyles, Harry E. . . . . 216 Elsby Bldg.

Weaver, Wm. W. . . . . 1104 E. Spring

Wohlfeld, Gerald . . . . . Silvercrest San.

Wolfe, Nelson . . . . . 1117 E. Spring

Worley, Henry L. . . . .

1104 E. Spring St.

**FOUNTAIN-WARREN COUNTIES**

Fisher, John E. . . . . Attica  
Freed, Carl A. . . . . Attica  
Freed, James C. . . . . Attica  
Maris, Lee J. . . . . Attica  
Pierce, Emmett, Jr. . . . . Attica  
Stephens, Lowell R. . . . . Covington  
Suzuki, T. T. . . . . Covington  
Priebe, Fred H. . . . . Hillsboro  
Smith, Byron J. . . . . Kingman  
McCord, Carl B. . . . . Veederburg  
Rusk, Hubert M. . . . . Wallace  
Nelson, Carl A. . . . . West Lebanon  
Crain, James W. . . . . Williamsport  
Himebaugh, Gilbert . . . . .

Mayo Clinic,

Rochester, Minn.

Lefforge, E. E. . . . . Box 858,

Patterson, Calif.

**FULTON COUNTY**

Herrick, Charles L. . . . . Akron  
Miller, Virgil . . . . . Akron  
Dielman, Franklin C. . . . . Fulton  
Kelsey, Lawrence E. . . . . Kewanna  
Kraning, Kenneth K. . . . . Kewanna  
Glackman, John C. . . . . Rochester  
Herendeen, Elbie V. . . . . Rochester  
Knotts, Slater . . . . . Rochester  
Richardson, Chas. L. . . . . Rochester  
Rowe, Howard H. . . . . Rochester  
Stinson, Arthur E. (S) . . . . . Rochester  
Stinson, Dean K. . . . . Rochester

**GIBSON COUNTY**

Geick, Raymond G. . . . . Fort Branch  
Hollis, Walter . . . . . Fort Branch  
Marchand, Austin F. . . . . Haubstadt  
Marchand, Edwin V. . . . . Haubstadt  
Petitjean, Harold G. . . . . Haubstadt  
Chappell, Harold R. . . . .

Oakland City



Ropp, Eldon R. . . . . Oakland City  
Turner, Maurice. . . . . Oakland City  
Wood, Russell W. . . . . Oakland City  
Geller, Samuel . . . . . Owensville  
Strickland, Karl S. . . . . Owensville

**Princeton**

Carpentier, Harry F. . . . .  
105 E. Broadway  
Folk, John K. . . . . 115 N. Prince St.  
Graves, Orville M. . . . . 115 S. Hart St.  
Hollingsworth, M. P. (S) . . . . .  
W. Broadway  
McCarthy, Virgil . . . . . 113 S. Main St.  
McElroy, Robert S. . . . . 116 S. Main St.  
Miller, Charles A. (S) . . . . .  
117 S. Hart St.  
Morris, W. F. (S) . . . . . 707 S. Main St.  
Peck, James F. . . . . 218 Broadway  
Weitzel, Roland . . . . . 112 S. Hart St.

**GRANT COUNTY**

Grant, M. Arthur . . . . . Fairmount  
King, Dale S. . . . . Fairmount  
Garrison, Leon J. . . . . Gas City  
Koontz, William A. . . . . Gas City  
Baskett, Russell J. . . . . Jonesboro

**Marion**

Abell, Chas. F. . . . .  
321 Marion Natl. Bk. Bldg.  
Alderfer, Henry . . . . .  
131 N. Washington St.  
Ayres, Wendell W. . . . . 302 Glass Blk.  
Bates, George . . . . .  
131 N. Washington St.  
Bloom, Asa W. . . . . 724 W. Third  
Boyer, Grace M. . . . . 313 Iroquois Bldg.  
Braunlin, Robert F. . . . .  
718 Marion Nat. Bank Bldg.  
Braunlin, William H. . . . .  
718 Marion Nat. Bank Bldg.  
Brown, Robert M. . . . .  
522 Marion Nat. Bank Bldg.  
Burge, A. D. (S) . . . . .  
204 Odd Fellows Bldg.

Comeau, Wm. J. . . . .  
Marion General Hospital  
Currie, Robert W. . . . . 413 Glass Block  
Daniels, Erle O. . . . .  
708 Marion Nat. Bank Bldg.  
Daniels, Geo. R. (S) . . . . . 324 Glass Blk.  
Davis, Joseph B. . . . .

131 N. Washington St.  
Davis, Merrill S. . . . .  
131 N. Washington St.  
Davis, Richard . . . . .  
131 N. Washington St.  
Diamond, Leo L. . . . .  
413 Marion Nat. Bank Bldg.  
Fisher, Henry . . . . . 1502 S. Wash.  
Ganz, Max . . . . . 930 S. Adams  
Gustafson, Carl J. . . . .

**Veterans Hospital**

Hummel, Russel M. . . . .  
317 Marion Nat. Bank Bldg.  
Jarrett, John C. . . . .  
131 N. Washington St.  
Lavengood, R. W. . . . . 225 Glass Blk.  
Long, Max R. . . . . 803 S. Boots  
Love, V. Logan . . . . .

131 N. Washington St.  
McCarthy, Daniel J. (S) . . . . .  
1104 W. 5th St.  
McIlwain, Eleanor E. . . . . 107 E. 31st  
McIlwain, Robt. E. . . . . 107 E. 31st  
Miller, H. Allison . . . . . 320 Glass Blk.  
Mintz, Alfred M. . . . . 1016 Euclid Ave.  
Powell, J. Paxton . . . . . 309 Glass Blk.

Renbarger, L. L. . . . . 1531 W. Second  
Rhorer, John G. . . . . 201 S. D St.  
Schimmelpfennig, Robert J. . . . .  
131 N. Washington St.  
Simmons, Fredk. H. . . . .  
520 Whites Ave.  
Skomp, C. E. . . . . Marion Gen. Hosp.  
Sthair, Phillip L. . . . . 506 Glass Block  
Warren, Carroll B. . . . .

313 S. Nebraska  
Weinberg, Samuel . . . . . 318 Glass Blk.  
Wicker, Eugene H. . . . .  
Marion General Hospital  
Woodbury, John W. . . . .  
131 N. Washington St.  
Wojcik, Ladislav D. . . . .  
131 N. Washington St.  
Young, Robt. G. . . . . 2927 S. Wash.

King, Peter C. . . . . Swayzee  
Taylor, Everett C. . . . . Upland  
Rifner, E. S. . . . . Van Buren

**GREENE COUNTY**

Graf, Jerome A. . . . . Bloomfield  
Mount, Mathias S. . . . . Bloomfield  
Turner, Harold B. . . . . Bloomfield  
Turner, Jack J. . . . . Bloomfield  
Van Sandt, Frank A. (S) . . . . .

Bloomfield  
Porter, Carl M. . . . . Jasonville  
Rotman, Harry G. . . . . Jasonville  
Rotman, Sam I. . . . . Jasonville  
Bailey, Edwin B. . . . . Linton  
Broshears, Kenneth . . . . . Linton  
Craft, William F. . . . . Linton  
Porter, George C. (S) . . . . . Linton  
Raney, Ben B. . . . . Linton  
Tomak, Milton E. . . . . Linton  
Woner, John W. . . . . Linton  
Hayter, Robert . . . . . Lyons  
Hamilton, M. Luther . . . . . Newberry  
Fender, Asa H. . . . . Worthington  
Moses, George E. . . . . Worthington  
Moses, Robert E. . . . . Worthington

**HAMILTON COUNTY**

Hicks, Joseph (S) . . . . . Arcadia  
McDaniel, Franklin P. . . . . Atlanta  
Donahue, Claude M. . . . . Carmel  
Havens, Oscar . . . . . Cicero

**Noblesville**

Ambrose, Jesse C. . . . . 298 N. 9th St.  
Campbell, Sam W. . . . . 952 Maple St.  
Harris, Robert F. . . . . 120 N. 11th St.  
Hash, John S. . . . . 139 S. 10th St.  
Hooke, Samuel W. . . . . 307 N. 9th St.  
Kraft, Haldon C. . . . . 195 S. 10th St.  
Shanks, Ray . . . . . 104 S. 10th St.  
Shonk, Harold W. . . . . 1084 Clinton  
Southard, Carl B. . . . . 55 S. 16th St.

Thayer, Jos. O. . . . . R.R. 1, Noblesville  
Griffith, James W. . . . . Sheridan  
Newby, Eugene . . . . . Sheridan  
Reck, John L. . . . . Sheridan  
Connoy, Andrew F. . . . . Westfield  
Connoy, Leo F. . . . . Westfield  
Tomlinson, C. H. (S) . . . . .  
615 Glenn Ave.  
Lake Bluff, Ill.

**HANCOCK COUNTY**

Scott, Robert S. . . . . Charlottesville  
Manifold, Harold M. . . . . Fortville  
Navin, Hugh K. . . . . Fortville

**Greenfield**

Allen, Joseph L. (S) . . . . .  
17 E. South St.  
Endicott, Wayne . . . . . 215 W. Main St.  
Gibbs, Charles M. (S) . . . . .  
203 E. North St.  
Gill, Dee D. . . . . 1001 N. State St.  
Henn, R. Anthony . . . . . New Bldg.  
Hunter, Donn . . . . . 940 N. State  
Kinneman, Robert E. . . . .  
124 N. State St.  
Kirby, Ted C. . . . . 114 N. State St.  
Vingis, Bronie . . . . .  
Woods, James R., Jr. . . . .  
11 N. State St.

Larrabee, Wm. H. (S) . . . . .

New Palestine  
Pierson, Thos. A. . . . . New Palestine  
Kuhn, Robert W. . . . . Wilkinson  
Titus, Charles R. (S) . . . . . Wilkinson

**HARRISON-CRAWFORD COUNTY**

Amy, William E. . . . . Corydon  
Blessinger, Louis H. . . . . Corydon  
Brockman, Wilfred . . . . . Corydon  
Dillman, Carl E. . . . . Corydon  
Baker, Guy D. . . . . Crandall  
Gobbel, N. E. . . . . English  
Benz, Jesse . . . . . Marengo  
Lynch, O. R. . . . . Marengo  
Mathys, Alfred . . . . . Mauckport  
Davis, Claude E. . . . . Milltown  
Neely, Alonzo S. (S) . . . . .

New Middletown  
Johnson, J. M. . . . . Palmyra

**HENDRICKS COUNTY**

Foltz, Lloyd E. . . . . Brownsburg  
Scudder, Arthur N. . . . . Brownsburg  
Ellett, John, Jr. . . . . Coatesville  
Elliott, Paul W. . . . . Danville  
Frantz, Mount E. . . . . Danville  
Koch, Elmer L. . . . . Danville  
Terry, Lloyd . . . . . Danville  
Ellis, Lyman H. . . . . Lizton  
Wiseheart, O. H. (S) . . . . . North Salem  
Scamahorn, Malcolm O. . . . . Pittsboro  
Scamahorn, Oscar T. . . . . Pittsboro  
Aiken, Milo M. . . . . Plainfield  
Cohen, Irving . . . . . Plainfield  
Johnston, Alan . . . . . Plainfield  
Stafford, James C. . . . . Plainfield  
Stafford, Wm. C. . . . . Plainfield  
Walker, Jack . . . . . Plainfield

**HENRY COUNTY**

Call, Earle B. . . . . Knightstown  
Dreyer, Ralph W. . . . . Knightstown  
Wiatt, Leonard . . . . . Knightstown  
Scheetz, Marion R. . . . . Lewisville  
Dragoo, Farrol . . . . . Middletown  
Hammer, Jay W. . . . . Middletown  
Stauffer, George E. . . . . Mooreland  
Marshall, Lloyd C. . . . . Mt. Summit  
New Castle  
Amos, Robert L. . . . . 213 Burr Bldg.  
Bitler, Clyde C. . . . . 1319 Church  
Bledsoe, James G. . . . . 319 S. 14th  
Burnett, Arthur B. . . . . 310 Burr Bldg.  
Canaday, Clifford E. (S) . . . . .

1411 Church  
Craig, Alexander F. . . . . R.R. 2  
Davies, Robert . . . . . 1319 Church St.  
Fisher, John E. . . . . 409 Burr Bldg.  
Foster, Ray T. . . . . Chrysler Corp.  
Harrison, B. L. . . . . 118 Jennings Bldg.



Heilman, William C. . . . 1319 Church  
Hill, Kenneth G. . . . 1319 Church  
Iterman, George E. . . . 1319 Church  
Kennedy, Walter U. . . . 214 S. 14th  
Life, Homer L. . . . 101 S. 11th St.  
McDonald, Frank C. . . . 527 S. Main St.

McElroy, James S. . . . 1319 Church  
Saint, William . . . 1319 Church St.  
Stout, Walter M. . . . 1319 Church  
Thorne, Charles E. . . . 200 N. 12th  
Tully, John A. (S) . . . 502 S. Main  
Vivian, Donald E. . . . Henry County Hospital

Wiggins, Dulania S. (S) . . . 1222½ Race

Robertson, William S. . . . Spiceland

### HOWARD COUNTY

Denton, Larkin D. . . . Greentown  
Shoup, Homer B. . . . Greentown

#### Kokomo

Adams, Charles J. . . . 618 Armstrong Landon Bldg.  
Alward, John H. . . . 401 W. Walnut St.

Ault, Carl H. . . . 421 W. North St.  
Boughman, Joe D. . . . 322 Armstrong-Landon Bldg.

Bowers, C. C. . . . 210 W. Mulberry  
Bowers, Garvey B. . . . 210 W. Mulberry  
Bowers, John A. . . . 210 W. Mulberry  
Bruegge, Theodore J. . . . 630 Armstrong-Landon Bldg.

Clarke, Elton R. . . . 304 W. Taylor St.  
Conley, Thomas M. . . . 520 Union Bank Bldg.

Craig, Reuben A. . . . 608 Armstrong-Landon Bldg.  
Craig, Reuben . . . 610 Armstrong-Landon Bldg.

Crawford, Theo. R. . . . 416 W. Sycamore

Earl, Max M. . . . 409 W. Taylor  
Ferry, P. W. . . . 406 Union Bk. Bldg.  
Golper, Marvin N. . . . St. Joseph Mem. Hosp.

Good, Richard P. . . . 308 Armstrong-Landon Bldg.  
Halfast, R. W. . . . 214 E. Mulberry

Hutto, William H. . . . 408 Armstrong-Landon Bldg.

Jewell, George M. . . . 508 Armstrong-Landon Bldg.

Knepple, LaMarr R. (S) . . . 325½ N. Main

Lung, Bruce D. . . . 410 Union Bk. Bldg.  
McClure, Warren N. . . . 407 W. Taylor St.

McIndoo, Ralph E. . . . 304 W. Walnut  
Meiner, Joseph A. . . . 911 S. Main

Mendelson, Stanley M. . . . 117 W. Markland

Morrison, William R. . . . 504 Union Bank Bldg.

Murray, Ernest C. . . . 207 E. Mulberry St.

Paris, Durward W. . . . 614 Armstrong-Landon Bldg.

Phares, Robt. W. . . . 905 W. Mulberry  
Prather, Philip E. . . . 117 W. Markland

Ramey, John W. . . . 107½ S. Union

Rhorer, H. M. . . . 210 W. Mulberry  
Rudicel, Max . . . 1604 Kingston Rd.

Schwartz, Frederick C. . . . 518 Armstrong-Landon Bldg.

Shenk, Earl M. . . . 208½ N. Main  
Smith, Gloster J. . . . 105½ E. Sycamore  
Sorenson, Raymond . . . 522 Armstrong-Landon Bldg.  
Spangler, Jesse S. . . . 215 E. Taylor

Evans, Robert M. . . . Russiaville

### HUNTINGTON COUNTY

#### Huntington

Brubaker, Harold S. . . . 42 W. Park Dr.  
Casey, Stanley M. . . . 408 E. Market  
Clunie, Wm. A. . . . 323 W. Park Dr.  
Cope, Stanton E. . . . 1022 N. Jefferson  
Erehart, Mark G. . . . 232 W. Market  
Eviston, John B. . . . 34 E. Wash.  
Galbreath, Russell S. . . . 16 W. Wash.  
Gray, Paul M. . . . 340 E. Market  
Grayston, W. S. (S) . . . 303 E. Market  
James, Thomas, Jr. . . . 48 E. Franklin  
Johnston, Robt. G. . . . 339 E. Market  
Marks, Howard H. . . . 248 W. Park  
Meiser, Robt. D. . . . 612 N. Jefferson  
Mitman, Floyd B. . . . 210 W. Park  
Nie, Grover M. . . . 220 W. Park Dr.  
Omstead, T. W. . . . 244 E. Washington  
Wagner, Richard . . . 1355 Guilford

Woods, Halden C. . . . Markle  
Bennett, J. B. . . . Warren  
Black, C. S. . . . Warren

### JACKSON COUNTY

Cummings, David J. (S) . . . Brownstown

Gillespie, Garland R. . . . Brownstown  
Shields, Jack E. . . . Brownstown  
Adair, William K. . . . Crothersville  
Bard, Frank B. . . . Crothersville  
Scharbrough, William . . . Medora

#### Seymour

Baxter, Harry R. . . . 4th & Walnut Sts.  
Black, Joe M. . . . 226½ S. Chestnut  
Bosch, Ralph . . . 635 W. 2nd St.  
Day, William D. C. . . . 515 W. 6th St.  
Elsner, Lawrence W. . . . 200½ W. 2nd St.

Gillespie, Charles E. . . . Seymour  
Graessle, Harold P. . . . Tipton & Chestnut Sts.

Kamman, Geo. H. (S) . . . 214½ S. Chestnut St.

Martin, Guy . . . 105 N. Walnut St.

Miller, Harold E. . . . Vehslage Bldg.

Osterman, Louis H. . . . 315 S. 2nd St.

Ripley, John W. . . . Seymour  
Shortridge, Wilbur H. . . . 201½ S. Chestnut St.

Wiethoff, Clifford A. . . . 327 Calvin

### JASPER-NEWTON COUNTIES

Pippenger, Wayne G. . . . Brook  
Coursey, James O. . . . Goodland  
Holland, Charles E. . . . Goodland  
Smith, Marsh H. . . . Goodland  
Yegerlehner, Roscoe S. . . . Kentland  
Merchant, Raymond . . . Lake Village  
Larrison, Glenn D. . . . Morocco  
Williams, H. J. . . . Morocco  
Hartsough, Ralph I. . . . Remington  
Schantz, Richard . . . Remington  
Beaver, Ernest . . . Rensselaer  
Johnson, Cecil E. . . . Rensselaer  
Kresler, Leon . . . Rensselaer

Ockerman, Kenneth R. . . . Rensselaer  
O'Neill, Martin . . . Rensselaer  
Titus, Jack L. . . . Rensselaer  
Gwin, Merle D. (S) . . . 2111 Regatta Ave.,  
Miami Beach, Fla.

### JAY COUNTY

Garber, Edwin C. . . . Dunkirk  
Hall, Emory H. . . . Dunkirk  
Heller, Nelson L. R. . . . Dunkirk  
Shroyer, Herbert . . . Dunkirk  
Hiestand, Harley J. . . . Pennville

#### Portland

Badders, Ara C. . . . 226 W. Main St.  
Cring, George V. . . . 210 W. Walnut St.

Cripe, William . . . 116 W. Walnut St.  
Fitzpatrick, James . . . 603 W. Arch St.  
Gillum, Eugene M. . . . Hawkins Bldg.  
Hammond, Stanley M. . . . Weiler Bldg.

Kealing, Forest E. . . . Lyon, Florence  
Moran, Mark M. . . . Spahr, Donald E. . . . 603 W. Arch St.  
Steffy, Ralph . . . 354 N. Jefferson  
Ralston John D. . . . Weiler Bldg.  
Lansford, John . . . Redkey

### JEFFERSON-SWITZERLAND COUNTY

Robertson, David W. (S) . . . Deputy  
Henning, Carl (S) . . . Hanover

#### Madison

Alcorn, Merritt O., Jr. . . . 428 E. Main St.  
Beetem, Luther F. . . . 425 W. Main  
Childs, A. G. W. (S) . . . 412 E. Main  
Childs, Wallace E. . . . 420 Elm  
Denny, Fred C. . . . Odd Fellows Bldg.  
Hare, Francis W., Jr. . . . Madison Clinic

Jolly, Lewis E. . . . Madison Clinic  
May, George A. . . . 426 E. Main  
McAtee, Otto B. . . . Madison State Hospital

Modisett, Jackson W. . . . Madison Clinic

Modisett, Marcella S. . . . Madison Clinic

Murray, William W. . . . Madison State Hosp.

Petway, Allen P. . . . 426 E. Main

Prenatt, Francis . . . Madison State Hospital

Shuck, Wm. A. . . . Odd Fellows Bldg.

Southworth, John W. . . . Madison State Hosp.

Turner, Anna L. . . . 104 E. Third  
Turner, Oscar A. . . . 104 E. Third

Whitsitt, Schuyler A. (S) . . . 718 W. Main

Zink, Robert O. . . . Madison Clinic

Bear, Lowery, H. (S) . . . Vevay  
Ellerbrook, George E. . . . Vevay  
Graves, Noel S. . . . Vevay  
Hamilton, Antha A. . . . Vevay

Cook, Elbert C. (S) . . . R.R. 1, Bradenton, Fla.

Hamilton, Guy (S) . . . 1420 Santa Domingo Ave.,  
Durate, Calif.

Nichols, Wm. G. . . . VA Hospital, Philadelphia 4, Pa.



**JENNINGS COUNTY**

Bruce, Reginald A. . . . . Butlerville  
Daubenheyer, Miles F. (S)

Butlerville  
Meyer, Hans. . . . . Butlerville  
Calli, Louis. . . . . North Vernon  
Green, John H. . . . . North Vernon  
Johnson, William A. . . . . North Vernon  
Matthews, Dennis W. . . . . North Vernon  
Neucks, Howard C.

R. R. 2, North Vernon  
Stemm, Wm. H. (S) . . . . . North Vernon  
Thayer, Benet W. . . . . North Vernon

**JOHNSON COUNTY**

Lutes, David L. . . . . Edinburg  
Michaels, Joseph F. (S) . . . . . Edinburg

**Franklin**

Chappel, Alfred T. . . . . 51 N. Water St.

Deppe, Charles F. . . . . 301 E. Jefferson St.  
Ferrara, Joseph F. . . . . 25 E. Madison  
Foster, Robert. . . . . 301 E. Jefferson  
Jones, Charles A. . . . . 251 E. Jefferson  
Murphy, Harry E. . . . . 150 N. Main St.  
Portteus, Walter L.

34 N. Water St.  
Province, Oran A. (S) . . . . . 100 N. Main St.

Province, William D. . . . . 100 N. Main St.

Records, Arthur W. . . . . 198 E. Jefferson St.

Stogsdill, Willis. . . . . 76 E. Jefferson

Barnes, Helen Beall. . . . . Greenwood  
Brown, George E. . . . . Greenwood  
Dagley, Hubert R. . . . . Greenwood  
Eaton, Lyman D. . . . . R. R. 1,  
Greenwood  
Sheek, Kenneth I. . . . . Greenwood  
Tiley, George A. . . . . Greenwood  
Woodcock, Charles E. . . . . Greenwood  
Machledt, John H. . . . . Whiteland  
Blackford, Florence

3015 Bellwood Court,  
Columbus, Ohio

**KNOX COUNTY**

Byrne, Robert J. . . . . Bicknell  
Donham, William L. . . . . Bicknell  
Fox, Richard H. (S) . . . . . Bicknell  
Meade, Walter W. . . . . Bicknell  
Waltz, Frank C. . . . . Bicknell  
Wilson, Guy H. . . . . Bicknell  
Scudder, John A. . . . . Edwardsport  
Hodges, William A. . . . . Oaktown  
Springstun, George H. . . . . Oaktown  
Pahmeier, John W. . . . . Sandborn

**Vincennes**

Anderson, John B. . . . . 301 LaPlante Bldg.  
Anderson, Richard M. . . . . 301 LaPlante Bldg.

Arbogast, Paul B. . . . . 915 Main  
Beckes, E. W. . . . . 603 Busseron St.  
Chattin, Herbert O. . . . . 729 Main  
Coffel, Melvin H.

424 LaPlante Bldg.  
Corsentino, Bart. . . . . Vincennes  
Cullison, Charles W. . . . . R.R. 4  
Curtner, Myron L. . . . . 222 N. Sixth  
Edwards, Edward T., Jr.

1045 Washington Ave.  
Ewing, Nathaniel D. . . . . 14 N. Third

Fox, Maurice S. . . . . 616 Shelby St.  
Gilmore, Louis L. (S) . . . . . 430 N. 2nd St.

Green, Carl L. . . . . 1004 Main  
Hoffman, Doris. . . . . 720 Perry St.  
Humphreys, Joe E. . . . . 217 N. Third  
Keezer, William S. . . . . 515 S. Perry  
McCormick, Hubert D.

325 LaPlante Bldg.  
McDowell, Mordecai M.

611 Dubois  
McMahan, Virgil C. . . . . 609 Dubois  
Meyer, Raymond C. . . . . Hillcrest Hosp.  
Moore, Robert G. . . . . 21 N. Third  
Nance, William K. . . . . 720 Perry St.  
Reilly, James F. . . . . 401 Buntin St.  
Richards, D. H. (S)

215 American Nat. Bk. Bldg.  
Schulze, William

223 American Bank Bldg.  
Shaffer, Kenneth L.

404 LaPlante Bldg.  
Smith, Ralph O. . . . . 603 Busseron  
Smith, Saml. J. . . . . 301 LaPlante Bldg.  
Spencer, Frederic. . . . . 429 S. 6th St.  
Sullenger, A. A. . . . . 605 Busseron  
Von de Leith, William C.

14 N. Third St.  
Welch, Norbert M.

410 LaPlante Bldg.  
Davis, Howard B. . . . . 404 Hazelgreen,  
Rock Hill, Mo.

**KOSCIUSKO COUNTY**

Thomas, Charles E. (S) . . . . . Leesburg  
Urschel, Dan . . . . . Mentone  
Stalter, Gaylord W. . . . . N. Webster  
Schuldt, T. S. . . . . Piercetown  
Clark, Fred . . . . . Syracuse  
Craig, Robert A. . . . . Syracuse  
Fosbrink, E. L. . . . . Syracuse  
DuBois, Charles C. (S) . . . . . Warsaw  
Haymond, George. . . . . Warsaw  
Hillery, John L. . . . . Warsaw  
Murphy, Harold O. . . . . Warsaw  
Richer, Orville H. . . . . Warsaw  
Roesch, Ryland. . . . . Warsaw  
Schlemmer, George H. . . . . Warsaw  
Thomas, Everett W. . . . . Warsaw  
Waltz, Frank C.

Box 1015, Punta Gorda, Fla.

**LAGRANGE COUNTY**

Wade, Alfred A. . . . . Howe  
Yunker, Philip E. . . . . Howe  
Benedict, Charles D. . . . . LaGrange  
Flannigan, Harley F. . . . . LaGrange  
Studebaker, Lloyd R. . . . . LaGrange  
Weir, Dale . . . . . LaGrange  
Williams, John H. . . . . Shipshewana  
Hildebrand, William O. (S) . . . . . Topeka  
Lehman, Kenneth M. . . . . Topeka

**LAKE COUNTY**

Bolin, John T. . . . . Cedar Lake  
King, Robert W. . . . . Cedar Lake  
King, William B. . . . . Cedar Lake  
Misch, William. . . . . Cedar Lake

**Crown Point**

Becker, Philip H.  
Lake County T. B. Sanitarium  
Birdzell, John P. . . . . 124 N. Main  
Carroll, Mary E. . . . . 124 N. Main  
DuSold, Donald D. . . . . 123 N. Court St.  
Gray, Daniel E. . . . . 235 S. Main  
Horst, William N. . . . . 123 N. Court St.  
Klaus, J. M. . . . . 224 S. Court

MacLeod, Donald F.

Lake Co. T.B. Sanitarium  
Monroe, F. Bruce. . . . . Crown Point  
Seyler, Anna G.

Lake County T. B. Sanitarium  
Steele, Everett B. . . . . 124 N. Main  
Troutwine, William. . . . . 224 S. Court

Adler, Edmund R. . . . . Dyer  
Jeans, Robert F.

Mercy Hosp. Dyer

**East Chicago**

Arnold, Marion F. . . . . 4239 Magoun Ave.  
Barron, Elmer A. . . . . 3406 Guthrie St.  
Beam, Vernon B. . . . . Du Pont Co.  
Beilke, Clifford A. . . . . 815 W. Chicago  
Benchik, Frank A.

4712 Magoun Ave.  
Benedek, Tibor. . . . . 3406 Guthrie St.  
Bernardi, Hugh. . . . . 3406 Guthrie  
Bonaventura, Angelo P.

3701 Main St.  
Boyd, Chas. S. . . . . 4739 Melville Ave.  
Boys, Fay F. . . . . 722 W. Chicago Ave.  
Brauer, Abraham A. . . . . 3528 Main St.  
Braun, Benjamin D.

St. Catherine's Hospital  
Broomes, Edw. L. . . . . 2301 Broadway  
Callahan, Richard H. . . . . 3704 Main St.  
Campagna, Ettro A. . . . . 3406 Guthrie  
Carleton, Edward H.

Inland Steel Co.  
Cole, Arthur V. . . . . 3406 Guthrie St.  
Corrao, Gaetano. . . . . 2220 Broadway  
Cotter, Edward R.

723 W. Chicago Ave.  
Dainko, Alfred J.

823 W. Chicago Ave.  
Ernst, H. C. . . . . 720 W. Chicago Ave.  
Fleischer, Jacob C. . . . . 3406 Guthrie  
Gardiner, H. Glenn. . . . . 3210 Watling  
Govorchin, Alexander

724 W. Chicago Ave.  
Grosso, William G.

722 W. Chicago Ave.  
Gustaitis, John W.

815 W. Chicago Ave.  
Hamilton, Robert C.

2602 E. 140th Place  
Hayes, Jesse D. . . . . 4742 Melville

Irish, Wilbur J. . . . . 806 W. Chicago Ave.

Johns, David R. . . . . 724 W. Chicago Ave.

Kamen, Jack M. . . . . 3406 Guthrie  
Komoroske, John E.

723 E. Chicago Ave.  
Levin, Eli . . . . . 3700 Main St.

McGuire, Desmond F. . . . . 3429 Michigan Ave.

Marks, Ora L. . . . . 815 W. Chicago Ave.

Nicosia, John B. . . . . 3701 Main St.  
Pascale, Luke R. . . . . 3406 Guthrie

Payne, Arthur C. . . . . 2020 Broadway  
Ramker, Daniel T.

3406 Guthrie Ave.  
Shapiro, Joseph. . . . . 3701 Main St.

Shulruff, H. I. . . . . 3701 Main St.  
Teegarden, Joseph A., Jr.

1919 E. Columbus Dr.  
Teegarden, Joseph A.

1919 E. Columbus Dr.  
Trepagnier, Francis B.

3616 Main St.  
Zallen, Stanley G.

720 W. Chicago Ave.  
Zivich, John M. . . . . 3701 Main St.



## Gary

Almquist, Carl O. . . . 504 Broadway  
 Almquist, Reuben E. . . 504 Broadway  
 Armalavage, Leon J. . .  
     2717 W. Wabash  
 Baitinger, Herbert M. . .  
     504 Broadway  
 Behn, Walter M. . . . 738 Broadway  
 Bendler, Carl H. . . . 738 Broadway  
 Bills, Robert N. . . . 504 Broadway  
 Boardman, Carl (S) . . 504 Broadway  
 Borak, Walter J. . . 6151 W. 25th Ave.  
 Borenstein, Herschel . .  
     757 Broadway  
 Brady, Samuel G. . . . 765 Broadway  
 Brandman, Harry . . . 504 Broadway  
 Brink, Calvin C. . . . 504 Broadway  
 Brincko, John . . . . 504 Broadway  
 Brown, David B. . . . 504 Broadway  
 Brown, Leo R. . . . . 3855 Broadway  
 Bullard, Mattie J. . . 524 Garfield St.  
 Burcham, James B. . . 738 Broadway  
 Burger, Robert A. . . Methodist Hosp.  
 Carberry, George A. . 738 Broadway  
 Carbone, Joseph A. . . 504 Broadway  
 Carmody, Raymond F. . .  
     504 Broadway  
 Chevigny, Julius J. . . 504 Broadway  
 Cooper, Leo K. . . . . 670 Hayes St.  
 Crossland, Steward H. .  
     560 Hayes St.  
 Danielecki, L. J. . . . 738 Broadway  
 Darling, Dorothy . . 1600 W. 6th Ave.  
 Davis, Neal, Box 928, Ogden Dunes  
 Dian, August J. . . . 729 Broadway  
 Dian, Julia . . . . . 584 Garfield  
 Dierolf, Edward J. . 504 Broadway  
 Donchess, Joseph C. . 215 Broadway  
 Doty, James R. . . . . 504 Broadway  
 Duncan, John S. . . . 2165 W. 11th St.  
 Elliott, Ralph A. . . . 504 Broadway  
 English, Hubert M. . . 673 Broadway  
 Espy, Theodore R. . . 1903 Broadway  
 Gannon, G. W. (S) . . . 602 Broadway  
 Goldberg, Harold B. . 515 Broadway  
 Goldstone, Adolph . . 757 Broadway  
 Goldstone, Joseph . . 757 Broadway  
 Goldstone, S. R. . . . 757 Broadway  
 Grant, Benjamin . . . 1706 Broadway  
 Gregoline, A. F. . . . 729 Broadway  
 Hedrick, James T. . . 1901 Broadway  
 Hodurski, Zigfield . . 4319 Broadway  
 Holmes, George W. . . 504 Broadway  
 Jahns, Albin A. . . . 504 Broadway  
 Jannasch, Maurice C. .  
     2717 W. Wabash Ave.  
 Johnson, Lonnie B. . .  
     123 W. 21st St.  
 Kendrick, Frank J. . . 504 Broadway  
 Khaton, Odessa M. . .  
     2107 Carolina St.  
 Kilmer, Warren L. . .  
     3538 Central, East Gary  
 Kobrin, Meyer W. . . . 729 Broadway  
 Kolettis, George J. . . 860 Broadway  
 Kopcha, Joseph E. . . . 504 Broadway  
 Korn, Jerome M. . . . 742 Broadway  
 Kron, R. Vincent . . .  
     3538 Central, East Gary  
 Lebioda, Henry S. . . . 8 W. Ridge Rd.  
 Lewis, George N. . . . 504 Broadway  
 Lorenty, Thaddeus B. .  
     738 Broadway  
 Lovell, Martin H. . . . 1606 Broadway  
 Lutz, Georgianna . . . 504 Broadway  
 McMichael, F. J. . . . 504 Broadway

## Majsterek, Stanley L.

1902 W. 11th Ave.  
 Marcus, Morris C. . . . 738 Broadway  
 Marshall, Millard R. . 504 Broadway  
 Mather, J. W. . . . . 3543 Central,  
     East Gary  
 May, Richard M. . . . 583 Broadway  
 Mercer, Arthur H. . .  
     1600 W. 6th Ave.  
 Minczewski, Richard C.  
     504 Broadway  
 Molengraff, Cornelius J.  
     527 Broadway  
 Moore, E. Gregory . . 1901 Broadway  
 Moore, Edwin G. . . . 1606 Broadway  
 Morris, Hyman . . . . 17 W. 8th Ave.  
 Moswin, Jack A. . . . 504 Broadway  
 Nelson, Walfred R. . 559 S. Lake St.  
 Neuwelt, Frank . . . 504 Broadway  
 Nilges, Richard G. . .  
     2717 Wabash Ave.  
 Ornelas, Jos. P. . . . 673 Broadway  
 Palmer, Russell H. . .  
     2006 W. 4th Place  
 Parratt, Louis W. . . . 708 Broadway  
 Pruitt, J. Edward . . 4119 Broadway  
 Reynolds, James S. . . 504 Broadway  
 Rebhun, Joseph . . . . 504 Broadway  
 Richter, Samuel . . . 1215 Madison St.  
 Robinson, Walter K. . 504 Broadway  
 Rosenbloom, Philip J. .  
     504 Broadway  
 Roth, Leo . . . . . 2801 W. 7th Pl.  
 Rubin, Simon S. . . . 504 Broadway  
 Ryan, Hubert J. . . . 504 Broadway  
 Sagel, Jacob . . . . . 504 Broadway  
 Sala, Joseph J. . . . 504 Broadway  
 Sala, Walter R. . . . 504 Broadway  
 Senese, Thos. J. . . . 504 Broadway  
 Shellhouse, Michael . .  
     3811 Washington St.  
 Shevick, Alexander . 504 Broadway  
 Skeen, Earl D. . . . . 504 Broadway  
 Slama, George D. . . . 3624 Buchanan  
 Slama, John T. . . . . 3520 Polk St.  
 Spellman, Frank W. . . 401 S. Lake  
 Spivack, Mary . . . . 673 Broadway  
 Sponder, Joseph . . . 1512 Broadway  
 Stimson, H. R. . . . . 504 Broadway  
 Stoycoff, Christo M. . 844 Broadway  
 Thomas, Daniel D. . . 738 Broadway  
 Thomas, Gerald J. . . 504 Broadway  
 Trinosky, Donald L. . 504 Broadway  
 Trinosky, Frank C. . . 504 Broadway  
 Turgi, Robert W. . . . 504 Broadway  
 Verplank, Grover L. . 527 Broadway  
 Vye, James P. . . . . 522 Broadway  
 Walters, Eleanore . . 607 Broadway  
 Washington, G. Kenneth  
     1606 Broadway  
 Weiskopf, Henry S. . . 504 Broadway  
 Westhaysen, Peter . . 504 Broadway  
 Wharton, Russell O. .  
     703 Johnson St.  
 White, W. J. (S) . . . . 790 Broadway  
 Wicks, Orlando C. (S)  
     560 Van Buren  
 Williams, Alexander S.  
     504 W. 25th St.  
 Williams, Edwin D. .  
     504 W. 25th Ave.  
 Wimmer, Robert N. . . 9 W. 6th St.  
 Yarrington, Charles W. (S)  
     607 Broadway  
 Yocum, Paul S. Jr. . . 738 Broadway  
 Yocum, Paul S. . . . . 738 Broadway  
 Yocum, Wm. S. . . . . 583 Broadway  
 Young, George M. . . 3776 Broadway

## Young, Robert L. . . . 11—7th Ave.

Hazinski, R. T. . . . . Griffith  
 Lundeberg, Ralph A. . . . Griffith  
 Malmstone, F. A. (S) . . . Griffith  
 Purcell, Richard J. . . . Griffith  
 Siekierski, Joseph M. . . Griffith  
**Hammond**  
 Allegetti, Michael L.  
     5404 Hohman Ave.  
 Amberg, Edward A. . 5618 Calumet  
 Arbeiter, Herbert I. .  
     5231 Hohman Ave.  
 Arrowsmith, James L.  
     5231 Hohman Ave.  
 Beconovich, Robt. . .  
     839-169th St.  
 Bethea, Dennis A. . . 1021 Field St.  
 Black, Charles E. . . .  
     6618 Kennedy Ave.  
 Carlo, Joseph F. . . .  
     5305 Hohman Ave.  
 Chidlaw, B. W. (S)  
     5141 Hohman Ave.  
 Clancy, James F. . . .  
     5231 Hohman Ave.  
 Cook, George M. . . .  
     5231 Hohman Ave.  
 Davis, Alice L. . . . . 5116 Hohman Ave.  
 Eggers, Ernest L. . .  
     5141 Hohman Ave.  
 Eggers, Henry W. . . .  
     5231 Hohman Ave.  
 Egnatz, Nicholas . . . 522 State St.  
 Elledge, Ray . . . . . 5231 Hohman Ave.  
 Fischer, Burrell . . .  
     7403 Van Buren Ave.  
 Friedman, Isadore E.  
     5246 Hohman Ave.  
 Geronimo, Manuel M.  
     7416 Calumet Ave.  
 Geronimo, Rita R. V.  
     7416 Calumet Ave.  
 Gevirtz, Milton B. . .  
     5246 Hohman Ave.  
 Groman, Herman C. . 137 Rimbach  
 Hansen, Arthur H. . .  
     5252 Hohman Ave.  
 Hickman, A. L. . . . 5231 Hohman Ave.  
 Hofmann, Andrew (S)  
     445 State St.  
 Hopkins, J. R. . . . . 5231 Hohman Ave.  
 Howard, William H. .  
     5231 Hohman Ave.  
 Husted, Robert G. . . . 7248 Forest  
 Jones, Eli S. . . . . 5231 Hohman Ave.  
 Kaplan, Benj. B. . . . 2035—169th St.  
 Kenney, Francis D. . .  
     5231 Hohman Ave.  
 Kolanko, Leon A. . . .  
     5435½ Hohman Ave.  
 Koransky, David S. . .  
     5231 Hohman Ave.  
 Kretsch, R. W. . . . . 5231 Hohman  
 Kuhn, Hedwig S. . . . 112 Rimbach St.  
 Kuhn, Hugh A. . . . . 112 Rimbach St.  
 Larrabee, James F. . .  
     5245 Hohman Ave.  
 Lautz, Herbert A. . . 112 Rimbach St.  
 Lazo, Vicente R. . . .  
     5446 Calumet Ave.  
 Lipsey, Alfred J. . . .  
     5252 Hohman Ave.  
 Long, Keith . . . . . 137 Rimbach  
 McLean, James S. . . .  
     5252 Hohman Ave.  
 McVey, Clarence A. . .  
     5231 Hohman Ave.



Marcus, Emanuel  
5252 Hohman Ave.  
Marks, Salvo ..... 409 Yale Bldg.  
Mason, Richard L. 132 Rimbach St.  
Matthews, Charles B. (S)  
5252 Hohman Ave.  
Modjeski, Joseph R.  
5451½ Hohman Ave.  
Modjeski, Raymond J.  
5231 Hohman Ave.  
Morrison, Lindsey (S)  
109 Rimbach St.  
Musacchio, Frederick A.  
330 City Hall  
Nakadate, K. James  
917 173rd Place  
Neal, Leonard W.  
5252 Hohman Ave.  
Nodinger, Louis ..... 540 165th St.  
Panares, Solomon V.  
5434 Hohman Ave.  
Peck, Edward A. .... 422 Conkey St.  
Peiffer, Geraldine M.  
5252 Hohman Ave.  
Pilot, Jean ..... 5231 Hohman Ave.  
Premuda, F. F. 6727 Kennedy Ave.  
Rasch, George C. Jr.  
5231 Hohman Ave.  
Rawlins, Carolyn M.  
422 Conkey St.  
Remich, Antone C. 137 Rimbach St.  
Rendel, Donald T.  
5231 Hohman Ave.  
Rhind, A. W. .... 5145 Hohman Ave.  
Rosenthal, Carl 5252 Hohman Ave.  
Rosevear, Henry S.  
5231 Hohman Ave.  
Row, Perrie Q. .... 5231 Hohman Ave.  
Rudolph, Franklin G.  
5231 Hohman Ave.  
Santare, Vincent J.  
5231 Hohman Ave.  
Schlesinger, Jacob  
6010 Columbia Ave.  
Schulfer, Richard J.  
7134 Calumet Ave.  
Shanklin, E. M. (S)  
6006 Hohman Ave.  
Skrentny, Stanley  
5231 Hohman Ave.  
Stasick, Murray ..... 60 Douglas St.  
Stern, Samuel L.  
5231 Hohman Ave.  
Stevens, Edwin W.  
5231 Hohman Ave.  
Tilka, Edward ..... 7134 Calumet Ave.  
Walker, Adolph P. 1135 River Drive  
  
Acos, James C.  
2805 Highway Ave., Highland  
Markey, Richard J. P.  
2805 Highway Ave., Highland  
Riordan, John F.  
2145 Lincoln St., Highland  
Sroka, Alexander G.  
2942 Highway, Highland  
Vore, Hugh A. .... 8680 Prairie Ave.  
Highland  
  
Hobart  
Bjorklund, C. Ray 447 E. Third St.  
Friedrich, Louis M. (S)  
614 E. Third St.  
Gill, John R. .... 447 E. Third St.  
Klaus, Julius M. .... 224 S. Court St.  
Markle, Joseph G. .... 201 Main St.  
McGue, Frank J. .... 108 E. Third St.  
Parker, Harry C. .... 831 Garfield St.  
Pike, Warren H. .... 447 E. Third St.

Reed, John ..... 520 E. Fourth St.  
Spears, John M. .... 520 E. Fourth St.  
  
Combs, Loyal W. .... Lowell  
Mirro, John A. .... Lowell  
Templin, David B. .... Lowell  
Campbell, Guy C. .... Munster  
Sroka, Stanley J. .... Munster  
Teplinsky, Louis L. .... Munster  
  
Whiting  
Apter, Julia T.  
1902 Indianapolis Blvd.  
Best, Robert C.  
1902 Indianapolis Blvd.  
Ferry, John  
1902 Indianapolis Blvd.  
Frankowski, Clementine E.  
1907 New York Ave.  
Greisen, Jack G.  
1902 Indianapolis Blvd.  
Jones, Clifford M.  
1902 Indianapolis Blvd.  
Kudele, Louis T. .... 1321 119th St.  
LaFollette, Forrest R.  
1900 Indianapolis Blvd.  
McCarthy, Jeremiah A.  
1341 E. 119th St.  
Rudser, Donald H.  
1902 Indianapolis Blvd.  
Silvian, Harry A. .... 1400 119th St.  
Smith, Theodore J.  
1902 Indianapolis Blvd.  
Stecy, Peter  
1902 Indianapolis Blvd.  
Steen, Lowell H.  
1900 Indianapolis Blvd.  
Thegze, G. A. .... 1344 119th St.  
Troy, Jack M.  
1902 Indianapolis Blvd.  
Weinberg, B. A. .... 1348 119th St.  
  
Bechtol, Lavon D.  
Baxter Labs., Morton Grove, Ill.  
Bergan, Joseph A.  
VA Hosp., McKinney, Texas  
Dassel, Paul M.  
44 S. 20th St., Maywood, Ill.  
Dest, Paul ..... 18139 Torrence Ave.,  
Lansing, Ill.  
Detrick, Herbert W.  
Box 203, Alamo, Texas  
Galante, Vincent J.  
11530 S. Campbell,  
Chicago, Ill.  
Goralka, Joseph J.  
6610 S. Fairfield,  
Chicago, 29, Ill.  
Justen, Jerome W.  
Ft. Monroe, Va.  
Kahan, Harry L.  
1748 E. 2nd St., No. 1,  
Tucson, Ariz.  
Kobrak, H. G. .... 950 E. 59th St.,  
Chicago 31, Ill.  
Kopanko, Bernard F. .... St. Mary's  
Hosp., Huntington, W. Va.  
Lewis, Marvin  
260 Broad Ave.,  
Leonia, N. J.  
Murphy, Joseph F.  
17634 Maple St.,  
Lansing, Ill.  
O'Connor James J.  
720 Las Olivas Dr.,  
San Gabriel, Calif.  
Schlesinger, Daniel J. Presbyterian  
Hosp., Pittsburgh, Pa.  
Shafer, Sid J.

55 E. Washington St.,  
Chicago, Ill.  
Storer, William R. .... Sturgis, Mich.  
Tyrrell, Joseph J. 800 State Line,  
Calumet City, Ill.  
Tyrrell, Thomas C.  
704 Wentworth Ave.,  
Calumet City, Ill.  
Wisniewski, Edward M. .... Box W,  
Newtown, Conn.  
Wood, Frederic W.  
1224 Manatee Ave.,  
Bradenton, Fla.

## LAPORTE COUNTY

Oak, David, Jr. .... Hanna  
Oak, David D. .... LaCrosse

## LaPorte

Carter, Fred S. .... 912 Indiana Ave.  
Cartwright, Jack D.  
806 Madison St.  
Elshout, Clem H. .... 1004 Indiana Ave.  
Fargher, Robert A.  
811 Jefferson Ave.  
Farnsworth, Samuel A.  
1012 Michigan Ave.  
Feinn, Harry S. 1013 Indiana Ave.  
Fischer, Carlton N.  
1001 Maple Ave.  
Jones, John C. .... 801 Madison  
Jones, Robert B.  
808 Michigan Avenue  
Kelsey, Robert M. .... 702 Maple Ave.  
Kepler, Robert W. 708 Harrison St.  
Kistler, James J. .... 911 Maple Ave.  
Kring, Gerald G. 704 Jefferson Ave.  
Larson, G. O. .... 1110 Indiana Ave.  
Linn, Elbert E. .... 809 Jefferson St.  
Martin, William B.  
812 Michigan Ave.  
Mead, Frank E. .... 810 Madison St.  
Morgan, Samuel P.  
810 Michigan Ave.  
Muhleman, C. E. .... 901 Indiana Ave.  
Philbrook, Seth S.  
705 Harrison St.  
Predd, Adolph C.  
909 Madison St.  
Richter, John C. 808 Michigan Ave.  
Ross, Wilbur W. (S) . 904 Madison  
Scott, John S. .... 806 Maple Ave.  
Simon, Arthur R. .... 806 Maple Ave.  
Von Asch, George . 912 Monroe St.  
Wilcox, Robert F. .... 808 Maple Ave.  
Wolf, William E.  
1406 Lincoln Way

## Michigan City

Armstrong, Thomas D.  
120 W. Ninth St.  
Arney, Amos ..... 125 E. 5th St.  
Baker, Warren . 427 Warren Bldg.  
Bankoff, Milton L. .... 125 E. 5th St.  
Bernoske, Daniel G. .... 731 Pine St.  
Brooks, Harry L.  
100 Beverly Court  
Burris, Floyd L. .... 731 Spring St.  
Carlson, Norman R. .... 229 E. 5th St.  
Cleveland, John B.  
801 W. Washington St.  
Fargher, Francis M.  
907 Washington St.  
Feerer, Donald 117 W. Seventh St.  
Flaherty, Walter T.  
1016 Washington St.  
Frost, Robert J. .... 817 Pine St.  
Gardner, Melvin D.  
801 Washington St.

Gardner, Russell A.  
801 Washington St.  
Gilmore, Robert W.  
2234 Oriole Trail  
Gilmore, Russell A.  
301 Warren Bldg.  
Grotts, Bruce F.  
801 Washington St.  
Henderson, N. C. . . . 131 E. 8th St.  
Hillenbrand, Charles  
128 W. Tenth St.  
Hoover, Ammon W. 125 E. 5th St.  
Jones, King Solomon  
328½ Franklin St.  
Kemp, John T. . . . . 122 E. 7th St.  
Kerrigan, John F.  
916 Washington St.  
Kerrigan, Robert L.  
916 Washington St.  
Kling, Victor F. . . . 507 Warren Bldg.  
Kohrman, Benjamin M.  
125 E. Fifth St.  
Krieger, George M.  
701 Washington St.  
Kubik, Francis J. . . . 201 E. 8th St.  
Meyer, Milo G. 801 Washington St.  
Milne, Walter S.  
916 Washington St.  
Molenda, Robert V. . . 902 Pine St.  
Olson, William H. . . . P. O. Box 41  
Paul, Leonard G. . . . 125 E. 5th St.  
Piazza, Leonard F.  
907 Washington St.  
Pilecki, Peter J. . . . 125 E. 5th St.  
Plank, C. Robert . . . 732 E. Pine St.  
Potter, Brian . . . . . 719 Franklin  
Reed, Nelle . . . . . 501 Pine St.  
Robrock, Lawrence M.  
315 Warren Bldg.  
Roberts, Thomas K.  
120 W. Ninth St.  
Rudisill, Robert . . . 125 E. 5th St.  
Shortall, James P.  
917½ Franklin St.  
Spinning, A. L. (S)  
Kenwood Place  
Stumer, Myer . . . . . 125 E. 5th St.  
Walters, William H. . . Warren Bldg.  
Warren, Frank R. (S)  
Pottawattomie Park  
Weeks, Patrick H. . . . 119 E. 6th St.  
Zalac, Donald A. . . . 723 Pine St.  
Zullo, Robert S. . . . Walters Clinic,

Weinstock, Adolph. Rolling Prairie  
Moosey, Louis . . . . . Union Mills  
Hetman, Mitchell J. . . . Westville  
Hoyt, John M.  
Beatty Mem. Hosp., Westville  
Sennett, Cecil M.  
Beatty Mem. Hosp., Westville  
Sisson, Helen M.  
Beatty Mem. Hosp., Westville  
Tempey, Fred W. Jr.  
Beatty Mem. Hosp., Westville  
Van Den Bosch, Wallace R.  
Beatty Mem. Hosp., Westville  
Benz, Owen . . . . . Wanatah

## LAWRENCE COUNTY

### Bedford

Allen, L. Howard . . . 1622 24th St.  
Austin, Richard P.  
209 Citizens Nat. Bank Bldg.  
Benham, L. E.  
206 Citizens Bank Bldg.

Bridwell, Edgar . . . . 1317 L St.  
Duncan, Raymond . . . 1317 L St.  
Dusard, Joseph C.  
304 Citizens Nat. Bank Bldg.  
Edmonds, Kendrick . . 1303 15th St.  
Emery, Charles B. . . . 1027 15th St.  
Fountaine, Thomas J.  
200 Citizens Nat. Bank Bldg.  
Hammel, Howard T.  
Citizens Nat. Bank Bldg.  
Kerr, Donald M. . . . . 1317 L St.  
Meyer, Orlando L. . . . 1317 L St.  
Newland, Arthur E. . . 1112 15th St.  
Noe, William R. . . . . 1307 L St.  
Scherschel, John P. . . 1711 H St.  
Smallwood, Robert B.  
204 Citizens Nat. Bank Bldg.  
Wohlfeld, Julius B. . . 1124 16th St.  
Woolery, Richard  
207 Citizens Nat. Bank Bldg.  
Wynne, Roland E.  
301 Citizens Nat. Bank Bldg.

Hamilton, James R. . . . Mitchell  
Oswalt, James Telfer . . . Mitchell  
Dollens, Claude . . . . . Oolitic

## MADISON COUNTY

Carpenter, John L. . . . Alexandria  
Gaunt, Everett W. . . . Alexandria  
Keller, Frank G. (S) . . Alexandria  
Leroy, Alvin G. . . . . Alexandria  
McClelland, Harry N. . . Alexandria  
Overpeck, George H. . . . Alexandria  
Shafer, Richard H. . . . Alexandria

### Anderson

Aagesen, Walter J.  
702 Citizens Bank Bldg.  
Armington, Charles L.  
657 Anderson Bank Bldg.  
Armington, John C. (S)  
657 Anderson Bk. Bldg.  
Armington, Robert L.  
318 Citizens Bank Bldg.  
Ashcraft, John R. . . . 1424 E. 8th St.  
Austin, Charles E.  
2108 Nichol

Austin, Maynard A. (S)  
238 W. 12th St.

Ayres, Kenneth D.  
2210 Meridian St.  
Baughn, William L. . . Delco-Remy  
Benoit, Merrill P. . . . Delco Remy  
Bixler, Donald P. . . . 1410 Brown St.  
Blassaras, Chris . . . 2005 Broadway  
Brauchla, Carl H. . . . 117 W. 17th St.  
Brock, Earl E. . . . . 931 Meridian St.  
Brown, James M. . . . 12 W. 29th St.  
Buckles, David L. St. John's Hosp.  
Conrad, Ernest M. (S)  
2124 Meridian

Dixon, Rex W. . . . . 934 W. 8th St.  
Doenges, James L.  
631 Citizens Bank Bldg.

Donaldson, Frank C.  
712 Anderson Bank Bldg.

Drake, John C.  
604 Anderson Bank Bldg.

Ellis, Seth W.  
717 Anderson Bank Bldg.

Elsten, Aubrey W.  
704 Anderson Bank Bldg.

Erehart, A. D.  
714 Anderson Bank Bldg.

Fischer, Warren E.  
St. John's Hospital  
Gante, Henry W.  
1110 N. Meridian St.  
Hart, William D.  
515 Citizens Bank Bldg.  
Hensler, Benton M.  
1709 Nichol Ave.  
Irwin, Seth . . . . . 2209 Cedar St.  
Jones, Albert T.  
530 Anderson Bank Bldg.  
Jones, Horace E.  
1110 Meridian St.  
Kelly, Wendell C. . . . 704 E. 8th St.  
King, Joseph W.  
1110 N. Meridian St.  
Kopp, Otis A. 1110 N. Meridian St.  
Lamey, James L.  
447 Citizens Bank Bldg.  
Lamey, Paul T.  
423 Citizens Bank Bldg.  
Larmore, Joseph L.  
612 Anderson Bank Bldg.  
Larmore, Sarah M. . . . . R. R. 8  
Litzenberger, Sam W.  
622 Citizens Bank Bldg.  
Long, Paul L.  
710 Anderson Bank Bldg.  
McDonald, Vergil G.  
1110 Meridian St.

Maxson, R. V. . . . . 3240 Maryland Dr.  
Meister, Doris (S)  
403 Citizens Bank Bldg.

Metcalf, George B.  
931 Meridian St.

Miley, Weir M. . . . . 717 Madison St.  
Morris, Robert A.  
320 Citizens Bank Bldg.

Neale, Alfred  
234 Citizens Bank Bldg.

Nelson, Paul L. . . . . 330 West 7th St.  
Nesbit, Leonard L.  
415 Citizens Bank Bldg.

Patterson, William K.  
St. John's Hospital

Polhemus, Warren C.  
1803 Pearl St.

Quickel, Daniel S. (S)  
5 Griffith Bldg.

Reed, Roger R.  
412 Anderson Bank Bldg.

Rosenbaum, Lloyd E.  
647 Citizens Bank Bldg.

Ross, Guy E.  
661 Citizens Bank Bldg.

Rozelle, Clarence V.  
615 Citizens Bank Bldg.

Sharp, William L.  
449 Citizens Bank Bldg.

Stamper, Joseph H.  
619 State Rd. 67 W.

Stamper, Robert J.  
619 State Rd. 67W

Swan, Richard C. . . . . Delco Remy  
Tracy, Julius R. . . . . 738 W. 8th St.

Webb, Harry . . . . . 105 W. 11th St.  
Wilder, Gordon B.  
338 W. 8th St.

Wilkinson, Roger L. . . 4 E. 38th St.  
Williams, Francis . . . 1132 Central

Williams, Robert H.  
1132 Central Ave.

Willson, Canby L.  
315 Anderson Bank Bldg.

Wright, Cecil S.  
523 Citizens Bank Bldg.

Zierer, R. O. . . . . St. John's Hosp.



## Elwood

Buechler, William F. 1300 Main St.  
 Drake, M. C. 1201 Main St.  
 Fitzpatrick, Harry W.  
 1309 S. Anderson St.  
 Hanson, Martin F.  
 1102 S. Anderson St.  
 Hoppenrath, Wesley M.  
 1300 Main St.  
 Hoppenrath, William H. (S)  
 1300 Main St.  
 Laudeman, Walter A.  
 1515 North A St.  
 Newcomer, Frank V.  
 608 S. Anderson St.  
 Ploughe, Ralph R. 517 S. Anderson  
 Scea, Wallace 1300 Main St.

Bishop, Harry A. Frankton  
 Ridgway, Alton H. Lapel  
 Rinne, John I. Lapel  
 Williams, Robert D. Markleville  
 Beeler, Franklin K. Pendleton  
 Dickey, William M. Pendleton  
 McLaughlin, Calvin P. Pendleton  
 VanNess, William C. Summitville  
 Guthrie, Francis C.

Vero Beach, Florida

Jarrett, P. E.  
 8574 Elm St., Fairchild, Wash.  
 York, Arthur F.  
 569 S. Cleveland Ave., No. 11,  
 St. Paul 5, Minn.

## MARION COUNTY

Berger, Morley  
 902 Main St., Beech Grove  
 Ferry, Francis A.  
 St. Francis Hosp., Beech Grove  
 Kim, Young D.  
 136 N. 17th St., Beech Grove  
 Ramage, Walter F.  
 244 S. First St., Beech Grove  
 Rhea, James C.  
 801 Main St., Beech Grove  
 Hade, F. L. Bridgeport  
 Zerfas, Leon G. R. R. 1. Camby  
 Garrison, James L. Cumberland

## Indianapolis

## A

Abreu, Benedict E.  
 1200 Madison (6)  
 Adkins, Harold C. 409 E. 30th (5)  
 Adkins, Onan C.  
 3635 Watson Rd. (5)  
 Albertson, Frank P.  
 3544 W. 16th St. (22)  
 Alred, Allen W.  
 349½ Limestone St. (2)  
 Aldrich, Harry D.  
 501 Hume Mansur Bldg. (4)  
 Aldrich, Howard  
 4316 E. Washington (1)  
 Alexander, Ezra D.  
 617 Indiana, No. 304 (2)  
 Allen, Robert K.  
 3202 N. Meridian St. (8)  
 Alvis, Edmond O.  
 320 Hume Mansur Bldg. (4)  
 Anderson, John T.  
 2033 N. Harding (2)  
 Anderson, Wendell C.  
 1330 W. Michigan (7)  
 Appel, Richard H.  
 320 Hume Mansur Bldg. (4)  
 Arbogast, J. L.  
 I.U. Med. Center (7)

Arbuckle, Russell L.  
 244 N. Meridian St. (4)  
 Arbuckle, Wm. E. 1156 Lee (21)  
 Arnold, Aaron L.  
 607 E. Maple Rd. (5)  
 Arnold, Robert D. 3419 E. 10th (1)  
 Aronson, Sidney S.  
 618 Hume Mansur Bldg. (4)  
 Aust, Charles H. General Hosp. (7)  
 Avery, George  
 2117 W. Washington St. (22)

## B

Bachmann, Arnold J.  
 3440 N. Meridian (8)  
 Bailey, Orville T.  
 1315 W. 10th St. (2)  
 Bakemeier, Otto H.  
 5503 E. Washington (19)  
 Balch, James F.  
 709 Hume Mansur Bldg. (4)  
 Ball, John R. 1418 W. 10th St. (2)  
 Ball, Joseph E. 4312 E. 10th (1)  
 Banister, Revel F. 2958 Central (5)  
 Banks, Horace M.  
 Methodist Hosp. (7)  
 Barry, M. Joseph, Sr.  
 508-509 Doctors' Bldg. (4)  
 Bartley, Max D.  
 803 Hume Mansur Bldg. (4)  
 Batman, Gordon W.  
 723 Hume Mansur Bldg. (4)  
 Battersby, J. Stanley  
 I. U. Medical Center (7)  
 Batties, Paul A.  
 308 Walker Bldg. (2)  
 Bauer, Thomas B.  
 408 Hume Mansur Bldg. (4)  
 Baum, Harry  
 VA Regional Office (9)  
 Baumeister, Herbert E.  
 3375 Forest Manor (18)  
 Beach, Robert R. 2630 E. 10th (1)  
 Beamer, Parker  
 I. U. Med. Center (7)  
 Bean, Joseph S. 1425 Berwick (22)  
 Beasley, Thomas J.  
 112 Berkley Rd. (8)  
 Beaver, Howard W.  
 11 E. Raymond (25)  
 Beck, Evart M.  
 633 E. Maple Rd. (5)  
 Becker, Harry G.  
 6060 College Ave. (20)  
 Beckman, Henry F. (S)  
 5245 Washington Blvd. (20)  
 Beeler, John W.  
 712 Hume Mansur Bldg. (4)  
 Beeler, Raymond C.  
 712 Hume Mansur Bldg. (4)  
 Behnke, Roy H.  
 3139 Bonham Dr.  
 Belt, James H. Riley Hosp. (7)  
 Berman, Jacob K.  
 807 Hume Mansur Bldg. (4)  
 Beverland, Malon E.  
 3036 E. Washington (1)  
 Bibler, Lester D.  
 811 Underwriters Bldg. (4)  
 Bird, Charles R. (S)  
 301 Hume Mansur Bldg. (4)  
 Blatt, A. Ebner  
 3209 N. Meridian (8)  
 Bloemker, Edward F.  
 2729 Shelby (3)  
 Boaz, John J. (S)  
 302 K. of P. Bldg. (4)  
 Boggs, Eugene F.  
 2901 N. Meridian St. (8)

Bohner, Caryle B.  
 822 Hume Mansur Bldg. (4)  
 Boling, Grover C., Jr.  
 5806 N. Parker, (20)  
 Bond, George S.  
 1221 N. Delaware St. (2)  
 Bond, Virginia  
 2012 Sharon Ave. (22)  
 Bond, William H.  
 I. U. Medical Center (7)  
 Bonsett, Charles A.  
 Methodist Hosp. (7)  
 Booher, Norman R.  
 447 E. Maple Rd. (5)  
 Booher, Olga Bonke  
 447 E. Maple Rd. (5)  
 Booth, Boynton H.  
 910 Hume Mansur Bldg. (4)  
 Bowers, Don D.  
 711 Underwriters Bldg. (4)  
 Bowman, George W.  
 5634 Carrollton Ave. (20)  
 Boyer, Edward B.  
 725 Hume Mansur Bldg. (4)  
 Boyer, Floyd A. 442 N. Drexel (1)  
 Boyer, Philip A.  
 1200 Madison Ave. (25)  
 Brady, Thomas A.  
 818 Hume Mansur Bldg. (4)  
 Brayton, John R.  
 704 Underwriters Bldg. (4)  
 Brayton, Lee 3342 N. Illinois (8)  
 Bridges, William L.  
 I.U. Medical Center (7)  
 Briggs, Robert W.  
 406 N. Senate  
 Brickley, Richard A.  
 605 Hume Mansur Bldg. (4)  
 Brodie, Donald W.  
 817 C. of C. Bldg. (4)  
 Brown, Archie E.  
 1220 S. Belmont (21)  
 Brown, David E.  
 520 Hume Mansur Bldg. (4)  
 Brown, DeWitt W.  
 920 Hume Mansur Bldg. (4)  
 Brown, Edward A. (S)  
 201 Fountain Sq. Th. Bldg. (3)  
 Brown, Frances T.  
 2126 N. Talbot (2)  
 Brown, Wendell E.  
 802 C. of C. Bldg. (4)  
 Browning, James S.  
 3209 N. Meridian (8)  
 Browning, William M.  
 3740 Central (5)  
 Bruetsch, Walter L.  
 Central State Hospital (22)  
 Buck, Charles E.  
 3506 Lesley Ave. (18)  
 Bunde, Carl A.  
 Pitman-Moore Co. (6)  
 Burdette, Harold F.  
 3202 N. Meridian (8)  
 Burghard, Rolla D.  
 3760 N. Sherman Dr. (18)  
 Burney, Leroy E.  
 1330 W. Michigan (7)  
 Butler, John O.  
 1105 E. Hanna Ave. (27)  
 Butler, Robert M.  
 2330 N. Arlington (18)  
 Buttz, Rose J. P. (S)  
 112 E. 13th (2)

## C

Cahn, Hugo M. 418 E. 30th (5)  
 Caldwell, Marilyn Riley Hosp. (7)



Call, Herbert F.  
321 Hume Mansur Bldg. (4)  
Campbell, John A.  
I. U. School of Medicine (7)  
Canaday, James W. (S)  
1229 Prospect (3)  
Caplin, Samuel S. . . . 111 E. 30th (5)  
Carson, Wayne  
1011 Hume Mansur Bldg. (4)  
Carter, Oren E. . . . 668 E. 38th (5)  
Champion, John P. 3712 E. 35th St.  
Chattin, Wm. R.  
1517 N. Emerson (19)  
Chen, Ko Kuei . . . Eli Lilly & Co. (6)  
Christian, William A.  
1481 W. 10th St. (2)  
Chroniak, Walter  
3941 N. Delaware (5)  
Clark, Cecil P.  
922 Hume Mansur Bldg. (4)  
Clark, Lawson J.  
3736 N. Delaware (5)  
Clevinger, William G.  
1610 Auburn St. (24)  
Close, W. Donald  
809 Hume Mansur Bldg. (4)  
Coble, Ralph R. (S)  
3311 N. Meridian (8)  
Coggeshall, Warren E.  
I. U. Medical Center  
Cohn, Alvin C. Methodist Hosp. (7)  
Collins, Hubert L.  
985 N. Arlington (19)  
Collins, James N.  
712 Hume Mansur Bldg. (4)  
Conley, Joseph L.  
2443 E. Washington (1)  
Conway, Chester C.  
4402 E. New York (1)  
Conway, Glenn . . . 1620 S. East (25)  
Cook, Charles J. (S)  
1206 Comar Ave. (3)  
Copeland, Samuel J. (S)  
427 Bankers Trust Bldg. (4)  
Cornacchione, Matthew  
814 S. East (25)  
Cortese, James V. 435 S. East (25)  
Cortese, Thomas A.  
435 S. East (25)  
Countryman, Frank W.  
3233 N. Meridian (8)  
Courtney, John W.  
424 Hume Mansur Bldg. (4)  
Cox, Clifford E.  
R. R. 14, Box 811 (20)  
Craft, Kenneth L.  
1002 Hume Mansur Bldg. (4)  
Craven, Howard T.  
922 Hume Mansur Bldg.  
Crawford, John A.  
301 Hume Mansur Bldg. (4)  
Culbertson, Clyde G.  
Lilly Research Lab. (6)  
Cullen, Paul K.  
422 Hume Mansur Bldg. (4)  
Culloden, William G.  
710 E. 46th (5)  
Cuthbert, Marvin  
607 Hume Mansur Bldg. (4)  
Czenkusch, Helen G.  
1914 MacArthur Lane (24)

D

Dalton, John E.  
707-708 Hume Mansur Bldg. (4)  
Dalton, William W.  
422 Hume Mansur Bldg. (4)

Daly, Joseph M.  
I. U. Med. Center (7)  
Daniel, John C.  
1008 Hume Mansur Bldg. (4)  
Davidson, Dale A.  
I. U. Medical Center (7)  
Davidson, N. Cort  
3008 Clifton (23)  
Davis, John A. . . . 2719 E. Mich. (1)  
Davis, Sam J.  
908 Hume Mansur Bldg. (4)  
Deal, Eleanor H. B.  
4909 W. 15th St.  
Speedway (24)  
Dearmin, Robert M.  
3233 N. Meridian (8)  
DeArmond, Murray  
723 Hume Mansur Bldg. (4)  
Deever, John W. . . . 4131 Shelby (3)  
DeMotte, C. Bowen  
808 C. of C. Bldg. (4)  
Denny, Forrest L.  
3351 W. 10th (22)  
Denny, James W.  
5504 E. Washington (19)  
Des Jean, Paul A.  
638 K. of P. Bldg. (4)  
DeWees, Dwight L.  
302 N. Bradley (1)  
Dill, Myron K.  
St. Vincent's Hosp. (7)  
Dilts, Robert Louis  
2521 E. 38th (18)  
Dintaman, Paul G.  
432 Bankers Trust Bldg. (4)  
Dirks, Kenneth R.  
1481 W. 10th St. (7)  
Donato, Albert M. 1429 Shelby (3)  
Doran, J. Hal  
720 Hume Mansur Bldg. (4)  
Dorman, Willis L.  
5508 E. Washington (19)  
Dowd, Joseph A.  
6177 College (20)  
Dugan, Thomas J. (S)  
2540 W. Washington (22)  
Dugan, William M.  
410 Hume Mansur Bldg. (4)  
Dulin, Basil B.  
I. U. Medical Center (7)  
Dunbar, Colin V.  
423-4 Hume Mansur Bldg. (4)  
Dunning, Lehman M.  
1561 College (2)  
Dupes, Lowell E.  
V.A. Hosp. Cold Springs Rd.  
Dyar, Edwin W.  
3202 N. Meridian (8)  
Dyke, Richard W.  
General Hospital (7)

E

Earp, Evanson B.  
717 Hume Mansur Bldg. (7)  
Eaton, Edwin R.  
1221 N. Delaware St. (2)  
Ebert, J. Wayne . . . 509 Lincoln (3)  
Eberwein, John H.  
5346 Washington Blvd. (20)  
Egbert, Herbert L.  
504 Hume Mansur Bldg. (4)  
Eicher, Palmer O.  
3209 N. Meridian (8)  
Eikenberry, Hugh W.  
616 Bankers Trust Bldg. (4)  
Eldridge, Gail E. . . 1440 E. 46th (5)  
Ellis, Bert E.  
303 Hume Mansur Bldg. (4)

Ellis, William N.  
1930 N. Houston (18)  
Emhardt, John T. 1621 S. East (25)  
Emhardt, John W. A.  
512 E. Minnesota (25)  
Ensminger, L. A. (S)  
1321 N. Meridian (2)  
Enzor, Ora K. . . . 4216 College (5)  
Ernst, Clifford E.  
428 Bankers Trust Bldg. (4)  
Evans, Frederick H.  
17½ W. 22nd St. (2)  
Evans, Paul V. . . . General Hosp. (7)  
Everly, Ralph V. . . 4216 College (5)

## F

Failey, Robert B., Jr.  
57 E. 57th St. (20)  
Farrell, Joseph T.  
2807 E. Michigan (1)  
Fausset, C. Basil  
2901 N. Meridian St. (8)  
Field, Don,  
3834 Rockville Rd. (22)  
Finfrock, James D.  
St. Vincents' Hosp. (7)  
Fisch, Charles  
3120 N. Meridian St. (8)  
Fischer, Albert A.  
1745 Howard St. (21)  
Fitzgerald, William J.  
313 Ftn. Sq. Bldg. (3)  
Flanigan, Meredith B.  
2920 W. 33rd (22)  
Flick, John J. . . . 1443 N. Penn. (2)  
Flora, Joseph O.  
4317 W. Washington (21)  
Folkening, Norval C.  
204 Ftn. Sq. Bldg. (3)  
Foreman, Harry L. . . 60 W. 30th (8)  
Forry, Frank  
I. U. Medical Center (7)  
Foster, Lee N.  
St. Vincent's Hosp. (7)  
Fouts, Paul J.  
522 Hume Mansur Bldg. (4)  
Franklin, William L.  
508 Hume Mansur Bldg. (4)  
Frazin, Bernard  
1481 W. 10th St. (2)  
Freeman, Max E.  
1745 Howard St. (21)  
Fromhold, Willis A.  
611 Bankers Trust Bldg. (4)  
Fry, Robert D.  
612 Hume Mansur Bldg. (4)  
Fullerton, Robert L. 3665 N. Ill. (8)  
Fultz, Roy L. . . . General Hosp. (7)  
Funkhouser, Elmer  
702 Underwriters Bldg. (4)  
Furgason, Paul C.  
1008 Hume Mansur Bldg. (4)

## G

Gabe, William E.  
612 Hume Mansur Bldg. (4)  
Gaddy, Euclid T.  
2602 W. Washington St. (22)  
Gallup, Palmer R.  
601 Inland Bldg. (4)  
Gambill, William D.  
1019 Hume Mansur Bldg. (4)  
Gammieri, Robert L.  
3326 Clifton (23)  
Garber, J. Neill  
806 Hume Mansur Bldg. (4)  
Garceau, George J.  
508 Hume Mansur Bldg. (4)

- Gardiner, Sprague H.  
314 Hume Mansur Bldg. (4)
- Gardner, Buckman  
St. Vincent's Hospital (7)
- Garfield, Martin D.  
3705 College (5)
- Garner, William (S)  
2911 E. 10th (1)
- Garner, W. Stanley  
2911 E. 10th (1)
- Garrett, John D. (S)  
510 Doctors Bldg. (4)
- Garrett, Robert A.  
I. U. Medical Center (7)
- Gastineau, David C.  
I. U. Medical Center (7)
- Gastineau, Frank M.  
407 Hume Mansur Bldg. (4)
- Gatch, W. D.  
605 Hume Mansur Bldg. (4)
- Gattman, George B.  
I. U. Med. Center (7)
- Geider, Roy A. 1443 Prospect (3)
- Genna, Mary E.  
I. U. Med. Center (7)
- Genovese, Pasquale  
1481 W. 10th St. (2)
- George, Charles L. 507 E. 34th (5)
- Gibson, Maxine  
5744 Broadway Terrace (20)
- Gick, Herman H.  
2705 E. Michigan (1)
- Gifford, Fred E.  
710 Hume Mansur Bldg. (4)
- Gillespie, Charles F.  
3209 N. Meridian (8)
- Gillespie, Jacob E.  
523 Hume Mansur Bldg. (4)
- Gillette, Edward P.  
St. Vincent's Hospital (7)
- Glass, Robert L.  
608 Hume Mansur Bldg. (4)
- Glendening, John L.  
128 Insurance Bldg. (4)
- Goldman, Samuel 1266 Oliver (21)
- Goodwin, Caroline J.  
1220 Pickwick Pl. (8)
- Gosman, James H.  
2901 N. Meridian (8)
- Graves, John W.  
949 Ellenberger Pky. E. Dr. (19)
- Green, Harrison  
1011 Hume Mansur Bldg. (4)
- Green, Oscar  
6203 Indianola Ave. (20)
- Greenbank, Richard K.  
1800 E. Tenth St. (1)
- Greene, Morgan E.  
4552 Brookville Rd.
- Greist, John H.  
2901 N. Meridian St. (8)
- Griffith, Harold R.  
1481 W. 10th St. (2)
- Griffith, Richard S.  
Lilly Clinic, Gen. Hosp. (7)
- Griffith, Ross E. 401 E. 34th (5)
- Grimes, Hubert... Gen. Hosp. (7)
- Grisell, Ted L.  
504 Hume Mansur Bldg. (4)
- Gutelius, Charles B. (S)  
3028 Park Ave. (5)
- H
- Habich, Carl  
702 Hume Mansur Bldg. (4)
- Hadley, David  
809 Hume Mansur Bldg. (4)
- Hadley, Murray N. (S)  
809 Hume Mansur Bldg. (4)
- Haggard, Edmund B.  
806 Board of Trade Bldg. (4)
- Hahn, E. Vernon  
914 Hume Mansur Bldg. (4)
- Hall, Frank M.  
141 S. Meridian St. (25)
- Hall, Jack R. 3342 N. Illinois (8)
- Hamer, Homer G.  
1711 N. Capitol (7)
- Hammond, James B.  
Lilly Clinic, Gen. Hosp. (7)
- Hampshire, Donald R.  
1443 N. Pennsylvania (2)
- Hampton, Hollis E. Jr.  
Methodist Hosp. (7)
- Hancock, John G.  
2226 W. Michigan (22)
- Hanley, Edward J., Jr.  
615 Hume Mansur Bldg. (4)
- Hann, Eldon C.  
2901 N. Meridian (8)
- Hanna, Duke, Jr.  
2901 N. Meridian (8)
- Hanna, Thomas A.  
1608 N. Lynhurst Dr. (24)
- Hansell, R. M. 7 N. Euclid (1)
- Harcourt, Allan K.  
812 C. of C. Bldg (4)
- Harding, M. Richard  
308 Hume Mansur Bldg. (4)
- Harding, Myron S.  
308 Hume Mansur Bldg. (4)
- Hare, Earl H.  
1481 W. 10th St. (2)
- Hare, Laura  
404 Hume Mansur Bldg. (4)
- Harger, Robert  
804 Hume Mansur Bldg. (4)
- Harold, Albert H. (S)  
7510 Allisonville Rd. (44)
- Harold, Norris E. (S)  
3545 N. Denny St. (18)
- Harris, Carl B.  
319 Hume Mansur Bldg. (4)
- Harris, Jackson  
1481 W. 10th St. (7)
- Harris, Paul N.  
Eli Lilly & Co. (6)
- Hasewinkel, Carroll W.  
Methodist Hospital (7)
- Haslinger, Clarence J.  
2151 E. New York (1)
- Hatfield, B. F.  
802 C. of C. Bldg. (4)
- Hatfield, Jack J.  
802 C. of C. Bldg. (4)
- Hatfield, N. W. 2032 N. Rural (18)
- Hatfield, Margaret  
1315 W. 10th St. (2)
- Hawk, James H.  
3736 N. Delaware St. (5)
- Haymond, Joseph L.  
3769 College (5)
- Hays, Everett L.  
2607 Manker Ave. (3)
- Hedrick, Philip W. 654 E. 54th (20)
- Heinrichs, Harry H.  
434 Bankers Trust Bldg. (4)
- Henderson, F. G. Eli Lilly & Co. (6)
- Henderson, Roscoe C.  
3131 Northwestern Ave. (23)
- Hendricks, J. D. (S)  
2230 N. Del. (5)
- Hendricks, John W.  
911 Hume Mansur Bldg. (4)
- Henry, Russell S.  
725 Hume Mansur Bldg. (4)
- Hepburn, C. K.  
524 Hume Mansur Bldg (4)
- Hershberger, Philip  
St. Vincent's Hosp.
- Hetherington, A. M.  
4121 E. New York (1)
- Hetherington, John A.  
822 Hume Mansur Bldg. (4)
- Heubi, J. E. 668 E. Maple Rd. (5)
- Hickman, W. F. 1210 Oliver (21)
- Hicks, Murwyn L.  
I. U. Med. Center (7)
- Hildebrand, John O., Jr.  
1527 W. 29th St. (23)
- Hill, Lloyd... General Hosp. (7)
- Hilldrup, Don G.  
5672 N. Illinois St. (8)
- Himebaugh, James R. S.  
2502 English Ave. (1)
- Himler, James M.  
809 Underwriters Bldg. (4)
- Hine, U. B. 4808 E. Mich. (1)
- Hines, Don C. Eli Lilly & Co. (6)
- Hodges, Fletcher (S)  
VA Regional Office (4)
- Hoffman, Herman  
2439 Central Ave. (5)
- Hofmann, J. William  
323 Hume Mansur Bldg. (4)
- Hollingsworth, A. A. (S)  
4032 E. Wash. (1)
- Holman, J. E., Jr. 3315 E. 10th (1)
- Holman, Jerome E., Sr.  
3315 E. Tenth St. (1)
- Holmes, John L.  
314 N. Miley Ave. (22)
- Holsinger, Robert  
General Hospital (7)
- Hood, A. A. 3205 Shelby St. (27)
- Hooley, Paul E. Gen. Hosp. (7)
- Horwitz, Thomas  
423-4 Hume Mansur Bldg. (4)
- Howell, Joseph D.  
760 Bankers Tr. Bldg. (4)
- Howell, Robert D.  
900 Underwriters Bldg. (4)
- Hoyt, L. H. Methodist Hosp. (7)
- Huber, Carl P.  
I. U. Med. Center (7)
- Huckleberry, Carl D.  
LaRue Carter Hosp. (7)
- Huddle, John R.  
2961 N. Sherman Dr. (18)
- Hudson, F. J. 3440 N. Meridian (8)
- Hughes, William F. (S)  
4025 N. Meridian St. (8)
- Hull, Ronald H.  
723 Hume Mansur Bldg. (4)
- Hummons, Francis D.  
729½ N. West St. (2)
- Hummons, H. L. 729½ N. West (2)
- Hungerford, Louis N.  
1481 W. 10th St. (2)
- Hurt, Laverne B.  
635 E. Kessler Blvd. (20)
- Huse, William M.  
703 Hume Mansur Bldg. (4)
- Hynes, Roy T. 633 E. 38th St. (5)
- I
- Irwin, Glenn W., Jr.  
I. U. Med. Center (7)
- Iske, Paul G.  
1015 Hume Mansur Bldg. (4)



## J

Jackson, Frederick E.  
510 Doctors Bldg. (4)

Jackson, James W.  
1330 W. Mich. (7)

Jackson, J. L. . . . . 3001 E. 10th (1)

Jaeger, A. S. (S)  
430 Bankers Tr. Bldg. (4)

Jaquith, Orville S. (S)  
261 Blue Ridge Rd. (8)

Jay, A. N. . . . . 3233 N. Meridian (8)

Jeffries, K. I. (S) . . . 807 Virginia (3)

Jenkins, R. E. 3311 N. Meridian (8)

Jennings, Frank L.  
V.A. Hosp., Cold Springs Rd.

Jewett, J. H. 3120 N. Meridian (8)

Jinks, C. H. . . . . 4216 College (5)

Jobes, James E.  
305 Traction Term. Bldg. (4)

Jobes, Norman E. (S)  
305 Traction Term. Bldg. (4)

Johnson, Thomas W.  
529 Bankers Tr. Bldg. (4)

Johnson, W. F. 2121 N. Harding (2)

Jones, Allen W.  
6058 College Ave. (20)

Jones, David E.  
828 C. of C. Bldg. (4)

Jones, F. P. . . . . 4212 E. Michigan (1)

Jones, Roland W.  
707 Hume Mansur Bldg. (4)

Joseph, R. M. . . . . 1615 S. East (25)

## K

Kahle, Dan B. . . . . General Hosp. (7)

Kahler, M. V. . . . . 2338 W. Mich. (22)

Kahn, A. J. . . . . 3120 N. Meridian (8)

Kahn, H. L. . . . . 3120 N. Meridian (8)

Kalb, E. L. . . . . 356 S. Emerson (19)

Kammen, Leo . . . . 3414 Clifton (23)

Kammen, Robt. . . . 3202 W. 16th (22)

Katterjohn, James C.  
313 Hume Mansur Bldg. (4)

Kauffman, Nelson N.  
2901 N. Meridian St. (8)

Kauffman, Sidney A.  
633 E. 38th St. (5)

Keenan, George B.  
Methodist Hosp. (7)

Keenan, R. L.  
615 Hume Mansur Bldg. (4)

Keever, C. H. . . . . 5214 College (20)

Keiser, Venice D.  
5709 Broadway (20)

Kelly, Don E.  
702 Underwriters Bldg. (4)

Kelly, John F.  
517 Hume Mansur Bldg. (4)

Kelly, Walter F. (S)  
6016 E. Washington (19)

Kelly, W. M. . . . . 5438 E. Wash. (19)

Kempf, G. F. . . . . General Hospital (7)

Kendrick, W. M. . . . 1829 E. 46th (5)

Kennedy, Hall 2152 N. Meridian (2)

Kennedy, H. F. . . . 1105 Prospect (3)

Kenyon, Omar A.  
General Hosp. (7)

Kerr, H. R. . . . . 2817 E. Wash. (1)

Ketcham, Jane M.  
514 Hume Mansur Bldg. (4)

Keyes, Robert C. . . . Riley Hosp. (7)

Kilgore, B. W. . . . . 3133 E. 38th (18)

Kime, Edwin N.  
711 Underwriters Bldg. (4)

King, William E.  
811 Hume Mansur Bldg. (4)

King, W. F. (S) 1330 W. Mich. (7)

Kingsbury, John K.  
5462 E. Washington (19)

Kinzel, Robert J. W.  
3120 N. Meridian (8)

Kinzie, M. Dale . . . 2025 Koehne (2)

Kirkhoff, Paul J.  
1517 N. Emerson (19)

Kirklin, Oren L.  
202 Hume Mansur Bldg. (4)

Kirtley, William R.  
Lilly Research Lab. (6)

Kiser, Edgar F.  
226 Hume Mansur Bldg. (4)

Kitterman, Harry E.  
510 Hume-Mansur Bldg. (4)

Klain, B. V. . . . . 4157 College (5)

Knight, Robert E.  
3233 N. Meridian (8)

Knowles, C. Y.  
Riley Hospital (7)

Knowles, Robert P.  
2901 N. Meridian St. (8)

Knox, Edwin S. . . . . Indianapolis

Kohlstaedt, George W.  
4505 Marcy Lane (5)

Kohlstaedt, Karl C.  
1 E. 36th St. (8)

Kohlstaedt, Kenneth G.  
General Hosp. (7)

Kohne, Robert W.  
St. Vincent's Hosp. (7)

Koons, Karl M.  
922 Hume Mansur Bldg. (4)

Kopecky, R. R.  
4131 Shelby St. (27)

Kornafel, L. H.  
608 K. of P. Bldg. (4)

Kraft, Bennett  
760 Bankers Tr. Bldg. (4)

Kriel, William B.  
5630 W. Washington St. (21)

Kuntz, Herman W.  
501 Hume Mansur Bldg. (4)

Kurtz, Fred B. (S)  
5520 N. Illinois St. (8)

Kurtz, P. L. . . . . 668 E. 38th (5)

Kwitny, I. J. . . . . 3209 N. Meridian (8)

## L

LaDine, C. B. . . . . 2508 Station (18)

Lamb, Emmett B.  
205 Hume Mansur Bldg. (4)

Lamb, Russell W.  
205 Hume Mansur Bldg. (4)

Lamber, Chet K.  
912 Hume Mansur Bldg. (4)

Langdon, Harry K. (S)  
3264 N. Penn. (5)

Laramore, Ward  
5835 N. Keystone (20)

Larkin, Bernard J.  
305 Hume Mansur Bldg. (4)

Lawler, G. F. . . . . 3934 E. 10th (1)

Lawrence, Edwin A.  
I.U. Med. Center (7)

Leasure, J. Kent  
611 Hume Mansur Bldg. (4)

Leatherman, Harter L.  
1531 Broadway (2)

Leedy, Gladys J.  
Central State Hospital (22)

Leff, Abe H. . . . . 712 E. 52nd (5)

Leffel, James M., Jr.  
3209 N. Meridian (8)

Leffler, William T.  
2141 E. 52nd St. (5)

LeMaster, Theodore R.  
805 Hume Mansur Bldg. (4)

Leonard, Henry S. (S)  
303 Hume-Mansur Bldg. (4)

Leser, Ralph U.  
3233 N. Meridian (8)

Levi, Leon . . . . . 40 W. 38th (8)

Levin, R. T. . . . . 3209 N. Meridian (8)

Libbert, Edwin L.  
VA Regional Office (4)

Libbert, Edwin L., Jr.  
5703 E. Washington (1)

Lichtenberg, Melvin  
535 E. 38th (5)

Lidikay, Edward C.  
621 Hume Mansur Bldg. (4)

Lindenborg, Paul G.  
1402 N. Olney (1)

Lingeman, Raleigh E.  
411 Hume Mansur Bldg. (4)

Lingeman, Roger E.  
2081 N. Emerson (18)

Link, Goethe (S)  
608 K. of P. Bldg. (4)

Linton, Charles D.  
6130 Carvel, No. 4 (20)

Little, J. W. (S) . . . 2735 E. 10th (1)

Little, William J.  
712 Hume Mansur Bldg. (4)

Lloyd, Frank P.  
2229 Northwestern Ave. (23)

Lochry, Ralph L.  
St. Vincent's Hosp. (7)

Loehr, William M.  
I. U. Med. Center (7)

Long, William H. R. R. 18, Box 534

Loomis, Norman S.  
5230 Kenwood (8)

Lord, G. C. . . . . 104 E. Maple Rd. (5)

Louden, Robert W.  
St. Vincent's Hosp. (7)

Love, G. N.  
1644 N. Delaware St. (2)

Lovelace, Daniel D.  
Methodist Hosp. (7)

Ludwig, O. D. . . . . 5433 Madison (3)

Lukemeyer, George T.  
I. U. Med. Center (7)

Lurie, Paul R.  
I. U. Medical Center (7)

Luros, J. Theodore  
2901 N. Meridian (8)

Lybrook, William B.  
3731 N. Keystone (18)

## M

McBride, James S.  
810 Hume Mansur Bldg. (4)

McCallum, J. T. C. 237 W. 46th (8)

McCartney, D. H.  
918 Hume Mansur Bldg. (4)

McCaskey, Carl H. (S)  
608 Guaranty Bldg. (4)

McClain, Edwin S.  
414 Hume Mansur Bldg. (4)

McCormick, C. O., Jr.  
621 Hume Mansur Bldg. (4)

McCormick, C. O., Sr.  
621 Hume Mansur Bldg. (4)

McCown, Percy E.  
521 Hume Mansur Bldg. (4)

McCoy, Melvin H.  
General Hosp. (7)

McDevitt, Daniel R.  
3202 N. Meridian (8)

McGrath, M. F. . . . 1929 E. 38th (18)

McGuff, P. E. 605 E. Maple Rd. (5)

McIntire, Clarence R.  
General Hosp. (7)

McIntyre, Charles J. (S)  
414 Hume Mansur Bldg. (4)

McIntyre, J. M.  
2901 N. Meridian St. (8)



- McKinley, A. David  
I.U. Hospitals (7)
- McKinstry, Homer R.  
707 Underwriters Bldg. (4)
- McMillan, Frederick G.  
1110 Odd Fellows Bldg. (4)
- McNamara, J. P. 5610 College (20)
- McQuiston, Ralph J.  
608 Guaranty Bldg. (4)
- McTurnan, Robert W.  
5646 N. Illinois (8)
- Mackey, H. S. . . . 4309 Central (5)
- Mackey, J. E. . . . General Hosp. (7)
- Madtson, A. R.  
822 Hume Mansur Bldg. (4)
- Magennis, H. L. 468½ W. Wash. (4)
- Manalan, M. M.  
5831 E. Washington St. (19)
- Manion, Marlow W.  
601 Hume Mansur Bldg. (4)
- Mann, Mortimer  
323 Hume Mansur Bldg. (4)
- Manning, K. Randolph  
723 Hume Mansur Bldg. (4)
- Manzie, Michael  
807 Hume Mansur Bldg. (4)
- Marks, Maurice I.  
2901 N. Meridian St. (8)
- Marsh, Carl M.  
Methodist Hosp. (7)
- Marshall, A. L., Jr.  
1330 W. Michigan St. (7)
- Marshall, C. R. . . . 43 W. 30th (8)
- Martin, H. E. . . . 1200 Madison (6)
- Martin, L. H. . . . 2626 W. Wash. (22)
- Martz, Bill L.  
Lilly Clinic, General Hosp. (7)
- Martz, Carl D.  
508 Hume Mansur Bldg. (4)
- Marvel, R. J. 3311 N. Meridian (8)
- Masters, John M.  
805 Hume Mansur Bldg. (4)
- Masters, Robert J.  
805 Hume Mansur Bldg. (4)
- Mather, Robert  
General Hosp. (7)
- Matthew, W. Burleigh  
520 Hume Mansur Bldg. (4)
- Matthews, B. J. . . . 4612 E. 10th (1)
- Matthews, W. M. . . . 4612 E. 10th (1)
- Meador, Eric B.  
Riley Hosp. (7)
- Megenhardt, D. S.  
1015 Hume Mansur Bldg. (4)
- Meiks, Lyman T. . . . Riley Hosp. (7)
- Melloh, A. F. . . . 2821 E. 10th (1)
- Mendenhall, Clarence D.  
4502 E. Wash. (1)
- Mentendiek, Maurice H.  
205 Hume Mansur Bldg. (4)
- Mericle, Earl W.  
920 Hume Mansur Bldg. (4)
- Merrell, Paul  
914 Hume Mansur Bldg. (4)
- Mertz, H. O. . . . 1711 N. Capitol (7)
- Mertz, John H. O.  
1711 N. Capitol Ave. (7)
- Middleton, H. N. . . . 1828 N. Ill. (2)
- Miller, J. Don  
514 Hume Mansur Bldg. (4)
- Miller, Joseph A.  
4634 E. Pleasant Run Pkwy.,  
N. Dr. (1)
- Miller, R. S. . . . 6211 College (20)
- Miller, Wallace E.  
510 Hume Mansur Bldg. (4)
- Mitchell, E. H. . . . 1023 King (22)
- Mitchell, Edward O.  
5704 N. Keystone (20)
- Moening, Walter P.  
618 K. of P. Bldg (4)
- Molt, William F. (S)  
529 Bankers Tr. Bldg. (4)
- Montgomery, William F.  
904 Hume Mansur Bldg. (4)
- Moore, Ben B.  
414 Hume Mansur Bldg. (4)
- Moore, Richard B.  
5005 N. Illinois (8)
- Moore, H. T. . . . 3220 N. Sharon (22)
- Morchan, Saml. . . . 3769 College (5)
- Morgan, Margaret E.  
1315 W. 10th St. (2)
- Moriarty, John R.  
5602 Madison (3)
- Morrison, Lewis E.  
603 Hume Mansur Bldg. (4)
- Morton, Walter P.  
623 Hume Mansur Bldg. (4)
- Moser, Rollin H.  
400 Hume Mansur Bldg. (4)
- Mosier, Jack M.  
2210 N. Kitley Ave. (18)
- Moss, Bobby L.  
4533 E. 21st St. (18)
- Moss, H. B. 1849 Nowland Ave. (1)
- Moss, Herschel C.  
1481 W. 10th St. (2)
- Mothersill, M. H.  
3650 College Ave. (5)
- Moulton, L. G. . . . 1327 N. Penn. (2)
- Mueller, L. B. . . . 4026 Broadway (5)
- Muller, L. P. 3120 N. Meridian (8)
- Muller, P. F. 3311 N. Meridian (8)
- Muller, Victor H.  
3731 N. Keystone (18)
- Mumford, E. B. (S)  
320 N. Meridian (4)
- Myers, Chas. W.  
R. 18, Box 256 (24)
- Myers, R. V. . . . 1904 N. Rural (18)
- N
- Nafe, Cleon A.  
822 Hume Mansur Bldg. (4)
- Nagan, Robert F.  
606 Hume Mansur Bldg. (4)
- Nay, Richard M.  
1007 Hume Mansur Bldg. (4)
- Need, L. T. . . . 1927 S. Meridian (25)
- Nester, H. G.  
Room 307, City Hall (4)
- Nicholas, Dennis  
2425 E. 38th St. (18)
- Nie, Louis W.  
2901 N. Meridian St. (8)
- Nielsen, Juul C.  
1315 W. 10th St. (2)
- Noble, Thomas B., Jr.  
19 W. 56th St. (8)
- Nolting, H. F. . . . 261 W. 40th (8)
- Norman, Olin B.  
922 Hume Mansur Bldg. (4)
- Norman, William H.  
908 Hume Mansur Bldg. (4)
- Norris, Howard Lee  
704 Hume Mansur Bldg. (4)
- Norris, Max S.  
514 Hume Mansur Bldg. (4)
- Nourse, M. H. 1711 N. Capitol (7)
- Nugent, E. J. Allison Div. GMC (6)
- O
- Ochsner, H. C. Methodist Hosp. (7)
- O'Dell, Thomas A.  
3627 N. Penn. St. (5)
- Offutt, Andrew  
1330 W. Michigan St. (7)
- Olvey, Ottis N. 3769 Park Ave. (5)
- O'Malley, Martha  
1330 W. Michigan St. (7)
- Orders, Clark E. (S)  
440 Bankers Tr. Bldg. (4)
- Oswald, Robert H.  
I. U. Med. Center (7)
- Otten, Claude F.  
812 C. of C. Bldg. (4)
- Ottinger, Ross C.  
912 Hume Mansur Bldg. (4)
- Owen, John E.  
605 Hume Mansur Bldg. (4)
- Owens, T. C. 2823 N. Meridian (8)
- Owens, Walter L.  
I.U. Medical Center (7)
- P
- Pandolfo, Harry 2206 Madison (25)
- Parker, G. F., Jr.  
1517 N. Emerson (19)
- Parker, J. F. . . . 1706 E. Wash. (1)
- Parker, Portia 2226 W. Mich. (22)
- Parr, Robert W. . . . 3740 Central (5)
- Patton, M. T. . . . 107 W. 30th (8)
- Paulissen, G. T. 741 Markwood (27)
- Pearson, Lyman R.  
311 Hume Mansur Bldg. (4)
- Pebworth, Aubrey C. (S)  
1625 W. Morris (21)
- Peck, F. B. . . . 740 S. Alabama (6)
- Peirce, J. D. . . . Eli Lilly & Co. (6)
- Pennington, Walter E.  
214 Hume Mansur Bldg (4)
- Permer, Erwin . . . 136 E. 30th (5)
- Perucco, Leo G.  
St. Vincent's Hosp. (7)
- Petranoff, T. V. 3367 W. Mich. (22)
- Pettijohn, Fred L. (S)  
2460 Central (5)
- Pfaff, Dudley  
VA Regional Office (4)
- Phillips, David L.  
3602 N. Meridian St. (8)
- Pickett, Robert D.  
400 Hume Mansur Bldg. (4)
- Pierce, William J.  
General Hosp. (7)
- Pietz, David G.  
1801 E. 34th St. (18)
- Pilcher, Jack E.  
201 Hume Mansur Bldg. (4)
- Plautz, Geraldine Z.  
820 N. Bradley (1)
- Pollock, Anthony J.  
1315 W. 10th St. (7)
- Popplewell, Arvine G.  
Sunnyside Sanitarium
- Porter, Dale . . . 1481 W. 10th St. (2)
- Price, Francis W.  
2020 Madison Ave. (25)
- Price, James O.  
906 Hume Mansur Bldg. (4)
- Pryor, R. C. . . . 6111 College (20)
- Q
- Quigley, Jos. B.  
4590 E. Kessler Blvd.
- R
- Rabb, Frank M.  
624 Hume Mansur Bldg. (4)
- Rabb, H. S. . . . 3139 E. 10th (1)
- Rader, George S.  
1010 Hume Mansur Bldg. (4)
- Radigan, L. R. I.U. Med. Center (7)
- Ramsey, Frank B.  
201 Hume Mansur Bldg. (4)

- Reed, Philip B. . . . 1800 E. 10th (1)  
 Rees, R. C. . . . 6114 E. Wash. (19)  
 Reid, Chas. A. . . . 2445 Shelby (3)  
 Reisler, Simon  
     318 Bankers Tr. Bldg. (4)  
 Rhodes, Theodore D.  
     R. R. 12, Box 241 R  
     7017 Pendleton Pike (26)  
 Rice, R. M. . . . 740 S. Alabama (6)  
 Richardson, Thad T.  
     513 S. Sherman Dr. (3)  
 Richter, Arthur B.  
     720 Hume Mansur Bldg. (4)  
 Ricketts, J. W.  
     2901 N. Meridian St. (8)  
 Ridgeway, O. W. (S)  
     411 E. 16th (2)  
 Rigg, John F.  
     421 Hume Mansur Bldg. (4)  
 Rinker, Earl B. . . . 22 E. 57th St.  
 Ritchey, James O.  
     608 Hume Mansur Bldg. (4)  
 Ritter, Wayne L.  
     404 Hume Mansur Bldg. (4)  
 Robb, John A.  
     238 Hume Mansur Bldg. (4)  
 Robertson, R. B. 6118 E. Wash. (19)  
 Rogers, Donald L.  
     3311 N. Meridian St. (8)  
 Rohn, Robert J.  
     420 Hume Mansur Bldg. (4)  
 Roller, C. W. (S) . . 1437 Shelby (3)  
 Romberger, F. T., Jr.  
     3440 N. Meridian (8)  
 Rosenak, Bernard D.  
     226 Hume Mansur Bldg. (4)  
 Rosenbaum, David  
     1481 W. 10th St. (2)  
 Rosenbaum, Irving, Jr.  
     401 E. 34th St. (5)  
 Ross, A. T. . . . I.U. Med. Center (7)  
 Ross, Glenn E.  
     1481 W. 10th St. (7)  
 Roth, Bertram  
     6378 College Ave. (20)  
 Row, D. Hamilton  
     906 Hume Mansur Bldg. (4)  
 Rubin, Gerald S.  
     624 Hume Mansur Bldg. (4)  
 Ruddell, Karl R.  
     3202 N. Meridian (8)  
 Rudesill, Cecil L.  
     405 Hume Mansur Bldg. (4)  
 Rudesill, Robert  
     3941 N. Delaware (5)  
 Rupel, Ernest  
     419 Hume Mansur Bldg. (4)  
 Rust, B. K. . . . . 3740 Central (5)  
 Ruth, M. L. . . . 4304 E. Wash. (1)  
 Rutherford, C. W. (S)  
     4601 N. Penn. (5)  
 Ryan, G. V. . . . . 2428 W. 16th (22)
- S
- Sage, Russell A.  
     505 Hume Mansur Bldg. (4)  
 Salb, John P. . . . . Gen. Hosp. (7)  
 Salb, Max C. 826 C. of C. Bldg. (4)  
 Salzman, Morris  
     1119 S. Meridian (25)  
 Sanders, Harry M.  
     3760 N. Sherman Dr. (18)  
 Sandorf, Marvin 1102 Prospect (3)  
 Schaefer, C. Richard (S)  
     224 N. Meridian, No. 20 (4)  
 Schechter, John S.  
     3209 N. Meridian (8)
- Schenck, Ralph E.  
     Methodist Hosp. (7)  
 Scheier, E. W. . . 1542 Prospect (3)  
 Schlaegel, T. F., Jr.  
     624 Hume Mansur Bldg. (4)  
 Schlegel, Donald M.  
     1015 Hume Mansur Bldg. (4)  
 Schmidt, L. F.  
     605 Hume Mansur Bldg. (4)  
 Schmidt, R. H.  
     268 Blue Ridge Rd. (8)  
 Schneider, C. J. 1008 N. Beville (1)  
 Schuchman, Abe  
     5878 Washington Blvd. (20)  
 Schuchman, Gabriel  
     3451 College (5)  
 Schulz, Dale M.  
     I. U. Med. Center (7)  
 Schuster, Dwight W.  
     723 Hume Mansur Bldg. (4)  
 Scott, Geo. 3636 Layman Ave. (18)  
 Scott, I. W. . . 3209 N. Meridian (8)  
 Scott, John R. . . . 510 E. 38th (5)  
 Scott, R. P.  
     209 Hume Mansur Bldg. (4)  
 Scott, S. L.  
     6325 Guilford Ave. (20)  
 Seagle, William C.  
     I. U. Med. Center (7)  
 Seaman, Charles F.  
     1010 Hume Mansur Bldg. (4)  
 Sedam, H. L. . . . 4173½ College (5)  
 Segar, Louis H.  
     633 E. 38th St. (5)  
 Seitz, Philip F. D.  
     I.U. Med. Center (7)  
 Sellmer, George W.  
     St. Vincent's Hosp. (7)  
 Sexson, H. T.  
     5455 N. Meridian (8)  
 Shafer, Marion R.  
     614 Hume Mansur Bldg. (4)  
 Shanafelt, Donald K.  
     Methodist Hosp. (7)  
 Sheehan, F. G. 6016 E. Wash. (19)  
 Sherster, H. 1135 S. Meridian (25)  
 Shrigley, Edward W.  
     I.U. Med. Center (7)  
 Shriner, Richard L.  
     1315 W. 10th St. (7)  
 Shullenberger, W. A.  
     3740 Central (5)  
 Shumacker, Harris B., Jr.  
     I.U. Med. Center (7)  
 Sicks, Okla. W.  
     606 Hume Mansur Bldg. (4)  
 Sidebottom, Earl  
     507 Hume Mansur Bldg. (4)  
 Siekerman, C. W.  
     2614 Madison (3)  
 Siersdorfer, Theodore N. (S)  
     6003 W. Wash. (21)  
 Sigmond, Harvey W.  
     301 Hume Mansur Bldg. (4)  
 Simmons, James E.  
     1949 E. 11th St. (1)  
 Simms, J. Leon  
     2638½ Northwestern (23)  
 Simpson, W. D.  
     6062 Lowell Ave. (18)  
 Sims, J. Lawrence  
     809 Hume Mansur Bldg. (4)  
 Sluss, D. H. . . 808 C. of C. Bldg. (4)  
 Sluss, John W. (S)  
     808 C. of C. Bldg. (4)  
 Smith, Charles F.  
     712 Hume Mansur Bldg. (4)
- Smith, D. J.  
     L. S. Ayres & Co. (9)  
 Smith, David L.  
     2901 N. Meridian St. (8)  
 Smith, Edward B.  
     I. U. Med. Center (7)  
 Smith, E. Rogers  
     822 Hume Mansur Bldg. (4)  
 Smith, F. C. 983 N. Arlington (19)  
 Smith, Lester A.  
     238 Hume Mansur Bldg. (4)  
 Smith, Roy Lee  
     707 Underwriters Bldg. (4)  
 Smith, W. F. . . . 3424 College (5)  
 Smith, William B.  
     2229 Northwestern (23)  
 Snapp, Richard A.  
     1481 W. 10th St. (7)  
 Snider, Byron . . . 2717 S. East (3)  
 Solomon, Reuben A.  
     414 Hume Mansur Bldg. (4)  
 Somers, Wm. H.  
     I. U. Med. Center (7)  
 Soper, Hunter A.  
     I. U. Med. Center (7)  
 Souter, M. C. 3360 N. Meridian (8)  
 Southard, James E.  
     914 Hume Mansur Bldg. (4)  
 Sovine, J. W.  
     720 Hume Mansur Bldg. (4)  
 Spahr, John F., Jr.  
     902 Hume Mansur Bldg. (4)  
 Spalding, Joseph J.  
     706 Hume Mansur Bldg. (4)  
 Sparks, Alan L.  
     1024 Hume Mansur Bldg. (4)  
 Speckman, Glenn H.  
     Methodist Hosp. (7)  
 Spivey, R. J. . . . 2616 N. Penn. (5)  
 Spolyar, L. W. . 1330 W. Mich. (7)  
 Spath, Carl B., Jr.  
     301 Doctors Bldg. (4)  
 Spath, Carl B., Sr.  
     301 Doctors Bldg. (4)  
 Stadler, H. E. . . 5508 E. Wash. (19)  
 Stanley, J. S.  
     Sunnyside Sanitarium (26)  
 Staten, Jesse C.  
     Methodist Hosp. (7)  
 Stayton, Chester A., Jr.  
     313 Hume Mansur Bldg. (4)  
 Stayton, Chester A., Sr.  
     313 Hume Mansur Bldg. (4)  
 Stephens, D. E. 6332 Guilford (20)  
 Stephens, K. H.  
     501 Hume Mansur Bldg. (4)  
 Stern, Nathan  
     3637 N. Illinois (8)  
 Stevens, S. L.  
     303 Hume Mansur Bldg. (4)  
 Stoelting, V. K.  
     I.U. Med. Center (7)  
 Stone, A. T. . . . 6202 College (20)  
 Stone, David F.  
     725 Hume Mansur Bldg. (4)  
 Storey, D. Edmund  
     813 Broad Ripple Ave. (20)  
 Storey, Jos. L. . . 3434 N. Ill. (8)  
 Storms, Roy B.  
     5041 Central Ave. (5)  
 Strange, Dempsey C.  
     1481 W. 10th St. (2)  
 Stroup, T. J. 216 K. of P. Bldg. (4)  
 Stucky, E. K. . . 1349 Madison (25)  
 Stump, Thomas A.  
     127 Blue Ridge Rd. (8)  
 Stygall, James H.  
     1221 N. Delaware (2)



Sudranski, Herbert F.  
824 Hume Mansur Bldg. (4)  
Sutton, William E.  
419 Hume Mansur Bldg. (4)  
Swan, John R.  
915 Hume Mansur Bldg. (4)  
Symmes, Alfred T.  
605 E. Maple Rd. (5)  
Szynal, Jno. S. 633 E. 38th St. (5)

## T

Talbott, Dan E.  
1020 Hume Mansur Bldg. (4)  
Tanner, Henry S.  
301 Hume Mansur Bldg. (4)  
Taube, Jack I.  
512 Hume Mansur Bldg. (4)  
Taylor, Clifford C.  
St. Vincent's Hosp. (7)  
Taylor, Frederic W.  
400 Hume Mansur Bldg. (4)  
Teague, Frank W.  
918 Hume Mansur Bldg. (4)  
Teixler, Victor A.  
224 Hume Mansur Bldg. (4)  
Test, Charles E.  
1002 Hume Mansur Bldg. (4)  
Teter, George V. . . . 401 E. 34th (5)  
Tether, J. E. . . . I.U. Med. Center (7)  
Tharpe, Ray . . . 3202 N. Meridian (8)  
Thatcher, Hugh K., Jr.  
110 W. Maple Rd. (8)  
Thom, Julia S. . . VA Reg. Office (4)  
Thomas, Edw. P.  
820 W. Michigan St.  
Thomas, Fred A.  
St. Vincent's Hosp. (7)  
Thomas, L. I.  
1008 Hume Mansur Bldg. (4)  
Thomas, Morris E.  
445 N. Penn., No. 715 (4)  
Thompson, Charles F.  
818 Hume Mansur Bldg. (4)  
Thompson, John V.  
1221 N. Delaware (2)  
Thompson, Paul D.  
404 Hume Mansur Bldg. (4)  
Thornburg, Kenneth E.  
1015 Hume Mansur Bldg. (4)  
Thornton, H. C.  
3769 College Ave. (5)  
Thrasher, John R.  
823 C. of C. Bldg. (4)  
Thurston, H. S. (S)  
2503 Prospect (3)  
Tindall, George T.  
6002 Windsor Drive (18)  
Tinsley, Frank W.  
603 K. of P. Bldg. (4)  
Tinsley, Walter B., Jr.  
3314 Carrollton (5)  
Tinsley, Walter B.  
603 K. of P. Bldg. (4)  
Tipler, Robert J.  
I. U. Med. Center (7)  
Tischer, E. Paul  
208 Hume Mansur Bldg. (4)  
Tondra, John M.  
408 Hume Mansur Bldg. (4)  
Toops, Thorndike C.  
1315 W. 10th (7)  
Torrella, J. A. . . . 5324 W. 16th (24)  
Tosick, William A.  
5662 Crestview Ave. (20)  
Toumey, Fred L.  
3209 N. Meridian St. (8)  
Trusler, Harold M.  
408 Hume Mansur Bldg. (4)

Tuchman, J. H. . . . 845 Grove (3)  
Tucker, R. L. . . . Eli Lilly & Co. (6)  
Tucker, Warren S.  
414 Hume Mansur Bldg. (4)  
Tyner, Harlan H.  
3202 N. Meridian St. (8)

## U

Ulrey, Robert P.  
St. Vincent's Hosp. (7)

## V

Van de Wetering, Robert  
6130 Carvel No. 11 (20)  
Vandivier, Robert M.  
209 Hume Mansur Bldg. (4)  
Van Dorn, Myron J.  
3626 Clifton (23)  
Van Fleet, Josephine  
VA Hosp., 2601 Cold Springs Rd.  
Van Meter, C. P. . . 3419 E. 10th (1)  
Van Nuys, John D.  
I.U. Med. Center (7)  
Van Nuys, Walter C. (S)  
Continental Hotel  
Van Osdol, Harry A.  
828 C. of C. Bldg. (4)  
Van Tassel, Charles J.  
709 Hume Mansur Bldg. (4)  
Van Vactor, Helen D.  
226 Hume Mansur Bldg. (4)  
Vellios, Frank  
I. U. Medical Center (7)  
Vollrath, V. J. . . . 5202 N. Ill. (8)  
Von Der Haar, Gerard  
4016 E. Michigan

Vore, Robert E.  
I. U. Medical Center (7)  
Voyles, Charles F. (S)  
715 Underwriters Bldg. (4)

## W

Waldo, J. Thayer  
610 Hume Mansur Bldg. (4)  
Walker, Frank C.  
414 Hume Mansur Bldg. (4)  
Walker, Robt. K. . . 413 E. 34th (5)  
Walther, J. E. 3202 N. Meridian (8)  
Walton, William M.  
General Hosp. (7)

Ward, Joseph H.  
2116 Boulevard Pl. (2)  
Ward, W. C. . . . . 116 E. 49th (5)  
Warfel, F. C. (S)  
4817 Broadway (5)  
Warman, Alvah P.  
1363 E. 38th St. (5)  
Warriner, James B.  
1012 N. Emerson Ave. (19)  
Warvel, John H.  
614 Hume Mansur Bldg. (4)  
Waymire, E. S. 1827½ College (2)  
Wehrman, Jule O. (S)  
4263 Washington Blvd. (5)

Weigand, C. G. 740 S. Alabama (6)  
Weil, H. J. . . . 443 N. Hamilton (1)  
Weinland, George C.  
2934 E. 39th St. (5)  
Weinsoff, Beverly  
425 Lansing (2)

Weiss, Jason . . . 4914 W. 16th (24)  
Weller, Charles A.  
3720 N. Delaware St.  
West, Jos. L. . . . 6318 W. Wash. (21)  
Westfall, B. K. . . . 2901 E. 38th (18)  
Westfall, John B.  
General Hosp. (7)  
Weyerbacher, A. F.  
663 E. 27th St. (5)

White, Donald J.  
502 Bankers Tr. Bldg. (4)  
White, John B.  
812 C. of C. Bldg. (4)  
White, Philip T.  
I. U. Medical Center (7)  
Whitehead, John M.  
1544 Roosevelt (1)  
Wilkens, I. W. . . . 1743 Shelby (3)  
Williams, Chas. D. 2405 Station (1)  
Williams, Clifford L.  
Central State Hospital  
Williams, Howard S.  
115 E. 16th St. (2)  
Williams, Hugh L.  
812 C of C Bldg. (4)  
Williams, Paul D.  
V.A. Reg. Office-36 S. Penn (4)  
Wilmore, Ralph C.  
I.U. Med. Center (7)

Wilson, Fred M.  
I.U. Medical Center (7)  
Wilson, O. R. 3519 Wash. Blvd. (5)  
Winters, Matthew . . 508 E. 38th (5)  
Wise, Wm. . . . . 120 E. 22nd (2)  
Wise, William R.  
General Hospital (7)

Wishard, Wm. Niles, Jr.  
1711 N. Capitol (7)

Witham, Robert L.  
I. U. Medical Center (7)

Wolfram, Don J.  
208 Hume Mansur Bldg. (4)  
Wood, D. E. . . . 6325 Guilford (20)  
Woodard, A. S., Jr.  
668 E. Maple Rd. (5)

Woolling, Kenneth R.  
718 Hume Mansur Bldg. (4)  
Worley, J. P. . . . 3705 N. Denny (18)  
Worley, Richard H.  
6016 E. Washington St. (19)

Wright, J. William, Jr.  
301 Hume Mansur Bldg. (4)  
Wright, J. William, Sr.  
301 Hume Mansur Bldg. (4)  
Wytenbach, John E.  
503 Hume Mansur Bldg. (4)

## Y

Yochem, August S.  
1315 W. 10th St. (7)  
Young, John E.  
812 C. of C. Bldg. (4)  
Young, J. M. 3209 N. Meridian (8)  
Young, J. W. . . . 6302 Guilford (20)  
Young, W. C.  
428 Bankers Trust Bldg. (4)

## Z

Zell, E. H. . . . 812 C. of C. Bldg. (4)  
Zerfas, C. P. A. . . . 2605 Shelby (3)  
Zerfas, Phyllis K. . . 2605 Shelby (3)

Bartle, James L. . . . . Lawrence  
Lewis, Robert J. . . . . Lawrence  
Asher, E. O. . . . . New Augusta  
Asher, James W. . . . . New Augusta  
Paynter, Morris B. . . . . Southport  
Jones, George L. . . . . Wanamaker

Berman, Edward J.  
707 Fullerton, Chicago, Ill.  
Berton, William M.  
887 Louise Circle, Durham, N.C.  
Blackwell, Milforde  
National Hosp.,  
London, England  
Bobb, Kenneth E.  
Camp Kilmer, N.J.



Bock, Don G.  
Fort Hood, Texas

Bowman, Harold E.  
5 Norwich Rd.,  
Pleasant Ridge, Mich.

Canganelli, Vincent G.  
Ingleside, Neb.

Caplin, Irvin  
V. A. Hosp., Aspinwall, Pa.

Carlson, Charles E.  
9856 S. Seeley Ave., Chicago, Ill.

Connerley, Marion L.  
3762 La Cresta Dr.,  
San Diego, Calif.

Cure, Charles  
149-I Wherry Housing,  
Fort Campbell, Ky.

Deer, Blan F.  
312 Fordham Dr.,  
Lake Worth, Fla.

Dester, Herbert E.  
Jagdeeshpur Via Raipur,  
C. P. India

Dryden, Gale E.  
869 N. 5th St.  
Covina, Calif.

Duckworth, Alda G.  
14536 Hamlin St.,  
Van Nuys, Calif.

Eastman, Joseph R. Jr.  
Chrysler Med. Dept.,  
Highland Park, Mich.

Eckert, Russell A.  
Ill. Masonic Hosp., Chicago, Ill.

Fisher, Gerald  
1120 Chester Ave., Cleveland 14, O.

Fosgate, Orville E.  
Briggs A. F. B., Texas

Freeborn, Warren S. Jr.  
150-5th Ave.,  
New York 11, N. Y.

Friedman, David K.  
4714 Crawford, Houston, Texas

Glendening, Richard L.  
Box 993, Springfield, Ill.

Graf, John E. (S)  
4332 N. Kilbourn  
Ave., Chicago 41, Ill.

Gregory, Charles F.  
1209 Lemon St.,  
Corona, Calif.

Griswold, Wait Robbins  
1277 Los Flores,  
Carlsbad, Calif.

Guthrie, James U.  
Nellis A.F.B., Nevada

Harvey, Verne K.  
39 River Road Terrace,  
Alexandria, Va.

Hull, James E. ....  
Lahey Clinic,  
Boston, Mass.

Jennings, F. Lamont  
5713 Drexel Ave.,  
Chicago, Ill.

Jewett, Robert E.  
911 Linwood Blvd.,  
Kansas City 3, Mo.

Langdon, J. Ray  
214 Gen. Krueger Blvd.,  
San Antonio, Tex.

Lanning, R. Adriar  
Maricopa Co., Hospital,  
Phoenix Ariz.

MacDonald, John A. (S)  
Interlaken, N. Y.

Mitchell, Raymond E.  
Veterans Admin.  
Springfield, Mo.

Morec, George J.  
Smoky Hill A.F.B., Kansas

Murray, James S. 606 N. Roxbury,  
Beverly Hills, Calif.

Norris, Mary Alice  
% Col. J. F. Surratt,  
Ft. Monroe, Va.

O'Brian, Earl J. ....  
582 W. 14th St.,  
San Pedro, Calif.

Osborne, Harry S. (S)  
R. 1, Box 337, Leesburg, Fla.

Raber, Robert M.  
4491 Osprey, San Diego, Calif.

Robinson, Frank C.  
14301 Bay Dr.,  
St. Petersburg 6, Fla.

Rogers, Thomas P.  
U.S.N. Hosp.,  
San Diego 33, Calif.

Ruddell, Keith R.  
20 Chapel St. 305C,  
Brookline, Mass.

Rudolph, Stephen J.  
Scott A.F.B., Ill.

Shugart, Joseph A.  
5520 St. Charles,  
El Paso, Texas

Thomas, Ralph G.  
Ft. Leonard Wood, Mo.

Tindall, Robert L.  
Jackson Mem. Hosp.,  
Miami, Fla.

Tinney, William E. (S)  
P. O. Box 1186,  
Pass-A-Grille Beach, Fla.

Topek, Nathan H.  
3902 Med. Grp., Offutt AFB, Neb.

Tucker, Leonard C. ....  
U.S.N. Hosp.,  
Bainbridge, Md.

Turrell, Eugene S.  
Univ. of Colorado, Denver, Colo.

Wilson, Douglas E.  
Percy Jones Hosp.,  
Battle Creek, Mich.

Ziperman, H. Haskell-M.C. O-63149  
141 Gen. Hosp., A.P.O. 1005  
c/o P.M., San Francisco, Calif.

### MARSHALL COUNTY

Kelly, Frank ..... Argos

Sheller, Thomas G. .... Argos

Connell, Vactor O. .... Bourbon

Marshall, George L. .... Bourbon

Bowen, Otis ..... Bremen

Cripe, Earl P. .... Bremen

Schreiner, John E. .... Bremen

Stine, Marshall E. .... Bremen

Baker, Milan D. .... Culver

Bills, L. F. (S) .... R. R. 1, Culver

Mackey, Colonel G. .... Culver

Reed, Donald ..... Culver

Reese, Lawrence W. .... Culver

Connell, Paul S. .... Plymouth

Danielson, Harry E., Jr. Plymouth

Klingler, Maurice O. .... Plymouth

Kubley, James ..... Plymouth

Pomeroy, Rex K. .... Plymouth

Reed, Robert G., Jr. .... Plymouth

Robertson, James S. .... Plymouth

Vore, L. W. .... Plymouth

Thompson, Alfred A. (S) ... Tyner

### MARTIN COUNTY

(See Daviess-Martin)

### MIAMI COUNTY

Shrock, Ethan E. .... Amboy

Line, Homer E. .... Chili

Frybarger, Samuel S. .... Converse

Malott, Frederick R. .... Converse

Sennett, Wm. K. .... Macy

Waite, Earl L. (S)  
Gilead Mail Macy

Rendel, Harold E. .... Mexico

Peru

Barnett, Ralph E. .... 65 N. Miami St.

Berkebile, John B. .... 15 W. 6th St.

Burrous, E. L. .... 27 W. 6th St.

Carlson, E. A. (S)  
11½ W. Main St.

Damiana, Pasquale G.  
11 W. 5th St.

Ferrera, Donald W. .... 16 W. 5th St.

Ferrara, Samuel J. .... 16 W. 5th St.

Herd, C. R. .... 15 S. Wabash

Johnson, Owen ..... 269 E. 4th St.

Lewis, Leonard D.  
111 N. Fremont St.

Lynn, Frank M. (S)  
24½ S. Broadway

Malouf, Stephen D.  
53½ S. Broadway

Person, Theodore ..... 86 Logan St.

Wildman, Roscoe E. .... 27 W. 6th St.

Yarling, John E. (S) .... 15 S. Wabash

### MONROE COUNTY

(See Owen-Monroe)

### MONTGOMERY COUNTY

#### Crawfordsville

Alexander, Stephen J.  
306 Ben Hur Bldg.

Ball, T. Z. (S)  
403 Ben Hur Bldg.

Burks, Jess Edwin  
403 Ben Hur Bldg.

Cooksey, Thomas L. (S)  
109½ S. Washington St.

Cornell, Robert A.  
219 Ben Hur Bldg.

Daugherty, Fred N. .... 120 W. Pike St.

Dodds, Wemple ..... Culver Hospital

Haller, Thomas C.  
411 Tinsley Ave.

Humphreys, John W.  
312 Jones Ave.

Kinnaman, Howard A.  
206 Ben Hur Bldg.

Kirtley, James M.  
416 Ben Hur Bldg.

Lingeman, Byron N.  
419 Ben Hur Bldg.

Millis, Robert J. .... 408 S. Grant Ave.

Mount, Wm. M. .... 413 Ben Hur Bldg.

Peacock, Norman F.  
219 Ben Hur Bldg.

Pierson, Robert H. .... 305 E. Main St.

Sharp, John L. .... 219 Ben Hur Bldg.

Wallace, Hawthorne C.  
411 Tinsley Ave.

Otten, Ralph E. .... Darlington

Blix, Fred M. .... Ladoga

Denny, Frank T. .... Ladoga

Davis, William ..... New Market

Kindell, Hurschell D.  
New Richmond

Hendrix, Claude A. .... Waveland

Johnson, Frank D. .... Waynetown

Parker, Carl B. .... Wingate

**MORGAN COUNTY**

Martinsville

Alexander, P. M.

Martinsville Sanitarium

Eisenberg, David A.

310 N. Main St.

Farr, James C. . . . . Martinsville

Gibbs, Joseph W.

Home Lawn Sanitarium

Gray, Leon. . . . . 171 E. Washington

Miller, Ray D. . . . . 290 E. Washington

Pitkin, Edward M.

195 E. Washington

Pitkin, McKendree C.

440 E. Washington

Van Wienen, John . . . . Martinsville

Willan, Horace R.

109 S. Jefferson St.

Murphy, Maurice G. . . . Morgantown

Seibel, Robert . . . . . Morgantown

Bivin, James H. . . . . Mooresville

Comer, Charles W. . . . . Mooresville

Comer, Kenneth E. . . . . Mooresville

Karpel, Bernard . . . . . Mooresville

VanBokkelen, Robert W.

Mooresville

**NEWTON COUNTY**

(See Jasper-Newton)

**NOBLE COUNTY**

Bowman, Charles M. . . . . Albion

Nash, Justin R. . . . . Albion

Mattmiller, Everette D. . . . Avilla

Sneary, Kenneth D. . . . . Avilla

Veazey, Wm. M. (S) . . . . . Avilla

Kendallville

Bryan, Robert E. . . . . 129 N. Main St.

Goodwin, Columbus B. (S)

Kendallville

Gutstein, Richard R. . . . Kendallville

Hepner, Herman

101½ N. Main St.

Lawson, Isaac H. . . . . Kendallville

Messer, Frank W. . . . . 115 E. Rush St.

Munk, Cleorie E.

210 W. Mitchell St.

Seybert, Joseph D. . . . . Kendallville

Stallman, Carl F. . . . . Kendallville

Williams, Harold O.

115 E. Rush St.

Young, Simon J. (S) . . . Kendallville

Schutt, James B. . . . . Ligonier

Stultz, Quentin F. . . . . Ligonier

Webster, Paul L. . . . . Ligonier

Fipp, August L. . . . . Rome City

Pulskamp, Bertrand H.

Wolcottville

Luckey, Harold A. . . . . Wolf Lake

Luckey, Robert C. . . . . Wolf Lake

Roth, James R. . . . . Wolf Lake

Switzer, Robert E.

U.S. Naval Hosp., Bethesda, Md.

**OHIO COUNTY**

(See Dearborn-Ohio)

**ORANGE COUNTY**

Keserik, Nicholas E. . . . French Lick

Sugarman, Benj. E. . . . French Lick

Take, John F. (S) . . . . French Lick

Colglazier, Granville G. (S)

Leipsic

Baker, Robert E. (S) . . . . Orleans

Hodgin, Philip . . . . . Orleans

Schoolfield, Wm. E. . . . . Orleans

Clark, Ivan A. . . . . Paoli

Hammond, Keith . . . . . Paoli

Spears, John K. . . . . Paoli

Boyd, Clarence E. (S) . . . West Baden

Miller, Henderson L. (S)

West Baden

**OWEN-MONROE  
COUNTIES**

Bloomington

Baxter, Neal E. . . . . 306 E. 5th St.

Bidney, Evelyn B.

321 S. Jordan Ave.

Borland, Raymond M.

114 N. Lincoln St.

Buckingham, Richard E.

344 College Ave.

Culmer, Walter N. (S)

432 S. College Ave.

DeMotte, Russell . . . 403 N. Walnut

Estes, Ambrose C. . . 300½ E. 5th St.

Fowler, Richard R.

108 S. Washington

Geiger, Dillon D. . . . 300 E. Kirkwood

Hardtke, Eldred F.

Indiana University

Hepner, Herman S. . . 312 N. Walnut

Holland, Deward J. (S)

313 N. College Ave.

Holland, Philip T. . . . 108 W. 7th St.

Karsell, William A.

306 East Kirkwood

Link, William C.

110 S. Washington St.

Lyons, Robert E. . . . . 321 E. 5th St.

Marchant, Clarence H.

350 S. College

Mason, Naiad . . . . . 811 S. Henderson St.

McLelland, Mary Rhamy . . R.R. 2

Middleton, Thos. O. . . 404 E. 7th St.

Owen, Abraham M.

200 S. Washington St.

Owen, Margaret A.

200 S. Washington St.

Pizzo, Anthony . . . . . Bloomington Hosp.

Poolitson, George C.

407 N. Walnut St.

Quarles, E. Bryan

811 S. Woodlawn

Ramsey, Hugh S. . . . . 307 E. 5th St.

Reed, William C. . . . . 307 E. 5th St.

Rieger, I. Taylor

108 S. Washington St.

Rogers, Otto F., Jr.

210 N. Washington St.

Rollins, Thomas K. . . 114 E. 7th St.

Ross, Ben R. . . . . 314 E. 7th St.

Schell, Harry D. . . . . 114 E. 4th St.

Schuman, Edith B.

Indiana University

Sibbitt, Joseph W. . . . 300 E. 5th St.

Smith, Herschel S.

110 S. Lincoln

Smith, Paul E. . . . . 812 North College

Smith, Rodney D. (S)

115 N. Washington St.

Spencer, Beaufort A.

114 N. Lincoln

Stangle, William J.

Bloomington Hospital

Topoligus, James N.

403 N. Walnut St.

Tripp, Harry D. . . . . 205 S. Walnut St.

Wellpott, Jean Franklin

Indiana University

Wilson, Talmage L.

301 E. Kirkwood

Dalton, Naomi L. . . . . V.A. Hosp.,

Houston, Texas

Stouder, Charles E. . . . . Gosport

Mitchell, George L. . . . . Smithville

Blackwell, Donald . . . . . Spencer

Brown, Marcel S. . . . . Spencer

Greene, Claude D. . . . . Spencer

Kay, Oran E. . . . . Spencer

Smith, Frederick R. . . . . Spencer

**PARKE-VERMILLION  
COUNTIES**

Brown, Ralph E. . . . . Cayuga

Darroch, Samuel . . . . . Cayuga

Casebeer, Paul B. . . . . Clinton

Evans, Frederick . . . . . Clinton

Gerrish, Wakefield D. (S) . . Clinton

Herzberg, Milton . . . . . Clinton

Kercheval, John M. . . . . Clinton

Pickett, Paul . . . . . Clinton

White, Isaac D. (S) . . . . . Clinton

Lauer, Dorothy B. . . . . Dana

Myers, William C. . . . . Dana

Gard, Daniel A. . . . . Marshall

Britton, Welbon D. . . . Montezuma

Johnson, William A. . . . . Perrysville

Bloomer, Joseph R. . . . . Rockville

Bloomer, Richard S. . . . . Rockville

Dowell, Emil H. . . . . Rockville

Harstad, Casper . . . . . Rockville

Merrell, Basil M. . . . . Rockville

McGilvray, Eva R. T.

Ind. State Sanitarium, Rockville

Pirkle, Hubert B.

Ind. State Sanitarium, Rockville

Staff, Robert A.

Ind. State Sanitarium, Rockville

Keith, Freeman E. (S) . . . St. Bernice

**PERRY COUNTY**

Bush, Hargis R. . . . . Cannelton

Tell City

Coultras, Porter J. . . . . 801 Main St.

Dome, Hardin S. (S) . . . 704 Ninth St.

Dukes, David . . . . . 521 Main St.

Glenn, Fred C. . . . . 436 Main St.

James, John M. . . . . 26 11th St.

James, Nicholas A. . . . . 746 Main St.

Lashley, Donald L. . . . . 606 Ninth St.

Lohoff, Lewis C. . . . . 507 Main St.

Neifert, Noel L. . . . . 507 Main St.

Snyder, Earl R. . . . . Troy

**PIKE COUNTY**

Dickinson, Gordon A. . . . Petersburg

Higgins, James L. . . . . Petersburg

Kime, John T. (S) . . . . Petersburg

Logan, Austin R. (S) . . . Petersburg

Omstead, Milton . . . . . Petersburg

DeTar, George B. (S) . . . Winslow

Dierdorf, Fred . . . . . Winslow

**PORTER COUNTY**

Dale, Joseph W. . . . . Chesterton

Griffin, Joseph P. . . . . Chesterton

Hall, Thomas C. . . . . Chesterton

Harless, Clarence M. . . . Chesterton

Robertson, William C. . . . Chesterton

Ashmore, Herbert C. . . . . Hebron

Kleinman, Francis J. . . . . Hebron

Valparaiso

Brown, James C.

Farmers State Bank

Davis, Carl M. . . . . 202 Indiana Ave.

DeGrazia, Eugene

810 LaPorte Ave.

DeWitt, Charles E. (S)

23 Lincoln Way



Dittmer, Jack . . . 23 Lincoln Way  
 Dittmer, Thomas L. (S) . . . 23 Lincoln Way  
 Douglas, Geo. R. (S) . . . 23 Lincoln Way  
 Eades, R. Charles . . . 501 E. Lincoln Way  
 Eades, Ralph C. . . 501 Lincoln Way  
 Frank, John R. . . 23 Lincoln Way  
 Green, Leonard J. . . 302 E. Lincoln Way  
 Makovsky, Theodore . . . 808 Lincoln Way  
 Miller, Ebbo H. . . . 608 Union St.  
 Milroy, Robert A. . . . Porter Mem. Hospital  
 Nash, Charles B. . . . 23 Lincoln Way  
 Poncher, Henry G. . . . Valparaiso University  
 Powell, Edgar H. (S) . . . 23 Lincoln Way  
 VanWinkle, Arthur J. . . 22 Franklin  
 Vietzke, Paul C. F. . . . 60 Jefferson  
 Gordon, Joseph L. . . . . Wheeler  
 Adair, Fred L. (H) . . . P.O. Box 158, Maitland, Fla.

### POSEY COUNTY

Ropp, Harold E. . . . New Harmony  
 Boren, Paul . . . . . Poseyville  
 Boren, Samuel W. (S) . . . Poseyville  
 Boyle, Carroll . . . . . Poseyville  
 Gailey, Ivan . . . . . Poseyville  
 Woods, Arba L. . . . . Poseyville  
 Challman, William B. . . Mt. Vernon  
 Herr, John W. . . . . Mt. Vernon  
 Hirsch, Herman L. . . . Mt. Vernon  
 Oliphant, Frank W. . . . Mt. Vernon  
 Vogel, L. John . . . . Mt. Vernon  
 Williams, Frederic . . . Mt. Vernon  
 Utley, Marvin D. . . 601 N. Broadway,  
 Baltimore, Md.

### PULASKI COUNTY

Dublin, Madeline . . . . Francesville  
 Ives, Raymond J. . . . Francesville  
 Linton, Charles E. (S) . . Medaryville  
 Carneal, Thomas E. . . . Winamac  
 Halleck, Harold J. . . . Winamac  
 Karns, John D. . . . . Winamac  
 Thompson, William R. . . Winamac  
 Yale, Charles A. . . . . Winamac

### PUTNAM COUNTY

Veach, Lester W. . . . . Bainbridge  
 Veach, Richard L. . . . . Bainbridge  
 Gray, Clyde C. . . . . Cloverdale  
 Greencastle  
 Dettloff, Frederick. . . 201 Walnut St.  
 Dobbs, O. R. . . . . R. R. 3  
 Fuson, Wenfred J. . . . Alamo Bldg.  
 Johnson, James B. . . . 105 E. Washington St.  
 Nichols, Anne Sackett . . 707 E. Seminary  
 Rhea, Gilbert D. . . . 126 E. Washington  
 Schauwecker, Cleon M. . . Hillsdale, Ave.  
 Steele, Dick J. . . . . Alamo Bldg.  
 Tennis, George T. . . . Alamo Bldg.  
 Tipton, William R. . . . 203 Northwood Blvd.  
 Wiseman, V. Earle . . . 239 Hillsdale  
 Gwaltney, Loral F. . . . Roachdale  
 Richards, Edgar E. . . . Russellville

### RANDOLPH COUNTY

Nixon, Byron . . . . . Farmland  
 White, Harvey E. . . . . Farmland  
 Harmon, Wayne . . . . . Lynn  
 Jordan, Leo E. . . . . Lynn  
 Martin, Charles E. . . . . Lynn  
 Slick, Crystal R. . . . . Lynn  
 Shallenberger, Henry R. . . Modoc  
 Hinchman, Jean . . . . . Parker  
 Henderson, Arvin . . . . Ridgeville  
 Potter, Richard M. . . . Ridgeville  
 Chambers, Leroy B. . . . Union City  
 Phipps, Leland K. . . . . Union City  
 Reid, Robert W. . . . . Union City  
 Rothermel, Harold . . . . Union City  
 Voisinot, Raymond A. . . . Union City  
 Wagoner, B. D. . . . . Union City  
 Dininger, William S. . . . Winchester  
 Engle, Russell B. . . . . Winchester  
 Koch, Howard W. . . . . Winchester  
 Painter, Lowell W. . . . Winchester  
 Robison, John S. . . . . Winchester  
 Sparks, Paul W. . . . . Winchester

### RIPLEY COUNTY

Erxleben, Walter O. . . . Batesville  
 Hisrich, Lloyd W. . . . . Batesville  
 Lippoldt, Charles L. . . . Batesville  
 Conrad, Henry W. . . . . Milan  
 Hunter, Lowell G. . . . . Milan  
 Warn, William J. . . . . Milan  
 Williams, Gilbert E. . . . Milan  
 Daley, Edward H. . . . . Oldenburg  
 Row, George S. . . . . Osgood  
 Smith, R. Lee . . . . . Osgood  
 McConnell, William C. . . Sunman  
 Fletcher, Charles F. . . . Sunman  
 Hopkins, Lester H. . . . Versailles  
 Moran, Noel D. . . . . Versailles

### RUSH COUNTY

Coleman, William S. (S) . Carthage  
 McNabb, George B. . . . Carthage  
 McNabb, Richard C. . . . Carthage  
 Sheets, Charles E. . . . . Manilla  
 Worth, C. Willard . . . . Milroy

#### Rushville

Atkins, C. C. . . . . 225 N. Morgan  
 Corpe, Kenneth F. . . . . R. R. 4  
 Dean, Donald I. . . . . 310 E. Fifth  
 Denny, Melvin H. . . . 127 W. Third  
 Ellis, Davis W. . . . . 229 N. Morgan  
 Green, Frank, Jr. . . . 134 E. Second  
 Johnson, Robt. B. . . . 229 N. Morgan  
 Kennedy, Robert O. (S) . . 118 W. Third  
 McKee, Harry G. . . . 4th & Main Sts.  
 Norris, Marvin G. . . . 134 E. Second St.

Nutter, W. H. . . . . 205 W. Third

### ST. JOSEPH COUNTY

Houser, D. Stanley . . . . Lakeville  
 How, John T. (S) . . . . Lakeville  
 Smith, Lee . . . . . Lakeville

#### Mishawaka

Barone, C. V. . . . 312 Lincolnway W.  
 Bassler, C. R. . . . Mishawaka Tr. Bldg.  
 Christophel, Verna . . 109 W. Third  
 Duvall, William N. . . 117½ Lincolnway E.  
 Farner, James E. . . . 114 Lincolnway West  
 Ganser, Richard A. . . 1020 Wilson Blvd.

Goethals, C. J. . . 602 Lincolnway W.  
 Martin, Charles F. . . 322 S. Mill St.  
 Orr, Robert . . . . 124 S. Race  
 Peltier, Hubert C. . . 114 Lincolnway, W.

Reed, Robert F. . . . 316 Lincolnway East  
 Rosenwasser, Jacob . . 228 Lincolnway East

Sirlin, Edw. M. . . . 111 S. Church  
 Spalding, Wendell L. . 427 Lincolnway East

Templeton, A. R. . . 522 Calhoun St.  
 Van Rie, Leo P. . . . 116 S. West  
 Walerko, Frank . . . 113 S. Church St.  
 Walters, Charles . . 319 S. Spring St.  
 Whitlock, Francis . . 110 N. Race St.  
 Whitlock, Merle E. . . 123 W. Fourth  
 Wixted, Jno. F. . . 314 Lincolnway E.  
 Wixted, Julia F. . . . 314 Lincolnway, E.

Wurster, Herbert C. . . 221 E. Third  
 Wygant, Marion D. . . 116 W. Third  
 Wyland, Byron J. . . 116 W. Third  
 Zimmer, H. J. . . 119½ Lincolnway W.

Luzadder, John E., Jr. . New Carlisle  
 Hardy, John J. . . . North Liberty  
 Warrick, Homer Lyle . . . Osceola

#### South Bend

Abel, Joseph A. . . 1222 Western Ave.  
 Acker, Robert B. . . 418 Sherland Bldg.

Arisman, Ralph K. . 110 W. Bartlett

#### B

Backs, Alton J. . . . 676 Lawndale  
 Balla, Morris . . . 404 Sherland Bldg.  
 Baran, Charles . . . 510 Sherland Bldg.  
 Bartsch, Harvey L. . 502 J.M.S. Bldg.

Bechtold, Samuel E. . 730 Sherland Bldg.

Bennett, Jene R. . . . 531 Main St.  
 Berke, Robert D. . . 102 E. Colfax Ave.

Biasini, Benedict A. . 401 Dixie Way North

Bickel, David A. . . 515 Odd Fellows Bldg.

Birmingham, Peter J. . 426 Sherland Bldg.

Bishop, Charles A. . . 122 N. Lafayette Blvd.

Bixler, Louis C. . . 615 Sherland Bldg.  
 Blackburn, Erwin . . 508 Sherland Bldg.

Bodnar, Leslie M. . . 525 N. Michigan

Borough, L. D. . . . 710 J.M.S. Bldg.

Bosenbury, Charles S. (S) . 323 W. Navarre St.

Brechtel, Harvey J. . . 728 W. Colfax

Bryan, Robert J. . . 1002 Lincolnway W.

Buchanan, Wallace D. . 825 Sherland Bldg.

Buechner, Frederick W. . 116 N. Main St.

Bussard, Clifford F. . . 202 Whitcomb-Keller Bldg.

Bussard, Frank . . . 202 Whitcomb-Keller Bldg.

Butts, Milton A. . . 1303½ W. Washington St.



C  
Carter, F. R. N. 605 Sherland Bldg.  
Cassady, James V.  
921 Lincoln Way East  
Clark, Stanley A. (S)  
1242 E. Jefferson St.  
Clark, William H.  
122 N. Lafayette Blvd.  
Colip, George D.  
514 Sherland Bldg.  
Condit, David H.  
122 N. Lafayette Blvd.  
Cook, Gordon C.  
122 N. Lafayette Blvd.  
Cooper, Harry L.  
410 Sherland Bldg.  
Crawford, Robert H.  
226 W. Colfax Ave.  
Culbertson, Carl S. 531 N. Main St.  
Custer, Edward W.  
Healthwin Sanitarium

D  
Denham, Robert H.  
425 Odd Fellows Bldg.  
Dietl, Ernest L. 822 Sherland Bldg.  
Dodd, Robert D. 759 Portage Ave.  
Dolezal, Bernard J.  
315 J.M.S. Bldg.  
Donnelly, Everett F.  
530 W. Indiana Ave.  
Duggan, James A. 110 Peashway  
Dunlap, D. Logan. 716 J.M.S. Bldg.

E  
Ebin, Judah L.  
706 Odd Fellows Bldg.  
Edwards, Bernard E.  
704 N. Main St.  
Egan, Sherman. 301 Sherland Bldg.  
Ellison, Alfred. 826 Sherland Bldg.  
English, John P.  
122 N. Lafayette Blvd.  
Ericksen, Lester G.  
615 Sherland Bldg.  
Erickson, Gustaf W.  
122 N. Lafayette Blvd.

F  
Faltin, Ladislaus  
609 Odd Fellows Bldg.  
Feferman, Martin E.  
510 Sherland Bldg.  
Feldman, Max. 1921 Miami St.  
Filipek, Walter J.  
311 Odd Fellows Bldg.  
Firestein, Ben Z. 703 J.M.S. Bldg.  
Firestein, Ray. 416 Sherland Bldg.  
Fish, Clyde M. (S)  
723 Sherland Bldg.  
Fish, Edson C.  
401 N. Notre Dame Ave.  
Fisher, Lawrence F.  
825 Sherland Bldg.  
Frank, Lyall L. 534 N. Lafayette  
Frash, DeVon W. 306 J.M.S. Bldg.  
Frey William B. 209 Poledor Bldg.  
Friedman, Morris S.  
315 Sherland Bldg.  
Frith, Gladys  
521 W. Washington Ave.  
Frith, Louis G.  
521 W. Washington Ave.

G  
Gates, George E.  
122 N. Lafayette Blvd.  
Gilman, Marcus M.  
403 Odd Fellows Bldg.

Giordano, Alfred S.  
1518 E. Colfax Ave.  
Godersky, George E.  
512 Odd Fellows Bldg.  
Goldstone, Harry A.  
Healthwin Hospital  
Graf, John P. 424 Peashway Ave.  
Green, G. F. 822 Sherland Bldg.  
Green, Norval E. 704 N. Main St.  
Grillo, Donald. 530 Sherland Bldg.  
Grorud, Alton C.  
120 Lafayette Blvd.

H  
Haley, Paul E. 401 Sherland Bldg.  
Hall, James M. 230 Sherland Bldg.  
Hamilton, Chas. D.  
1498 Northern Ave.  
Harmon, V. E. 302 Sherland Bldg.  
Haugseth, Ellsworth K.  
122 Lafayette Blvd.  
Helmen, H. W. 120 Franklin Place  
Helmer, John F.  
826 Sherland Bldg.  
Hilbert, J. W. 410 W. Washington  
Hildebrand, John O.  
1724 Lincolnway E.  
Hill, Theodore A.  
527 W. Colfax Ave.  
Hillman, M. W. 429 Sherland Bldg.  
Hillman, W. H. (S)  
429 Sherland Bldg.

Hoffman, R. V.  
1530 E. Jefferson Blvd.  
Holdeman, L. S. 404 N. Lafayette  
Holdeman, R. W. 404 N. Lafayette  
Holtzman, Norman H.  
3123 S. Michigan St.  
How, Louis E. 6101 S. Michigan  
Hyde, C. C. 122 N. Lafayette

J-K  
Joest, Charles O. 113 S. Church St.  
Johns, N. C. 718 Sherland Bldg.  
Kamm, B. A. 526 Sherland Bldg.  
Karn, John. 728 W. Colfax Ave.  
Klahr, Elsworth. 704 N. Main St.  
Knapp, Arthur L. (S)  
2215 Mishawaka  
Knode, K. T. 729 Sherland Bldg.  
Kramer, Albert A. (S) 1519 Miami  
Krueger, John E.  
401 N. Notre Dame Ave.  
Kuhn, F. L. 1215 S. Michigan

L  
Lamb, J. Leonard. 730 J.M.S. Bldg.  
Lane, William H. 604 N. Main  
Lang, Joseph E. 318 Sherland Bldg.  
Langenbahn, Carl J.  
206 Sherland Bldg.  
LaRocca, Joseph. 202 E. Bartlett  
Levantini, Bernard I.  
711 Odd Fellows Bldg.  
Lionberger, John R.  
615 Sherland Bldg.  
Liss, E. C. 317 Odd Fellows Bldg.  
Littlefield, Paul A. 604 N. Main St.  
Lockhart, Philip B.  
825 Sherland Bldg.  
Luginbill, Howard M.  
3201 Mishawaka Ave.  
Lyons, Robert C. 531 N. Main St.

M  
Mason, Bernard A.  
122 N. Lafayette Blvd.  
McCraley, W. J. 406 Sherland Bldg.  
McDonald, R. M. 410 J.M.S. Bldg.

McFarland, Corley B.  
122 N. Lafayette Blvd.  
McKenna, H. J. 1615 E. Wayne  
Metcalf, Grant E.  
319 Odd Fellows Bldg.  
Mikesch, W. H. (S)  
816 Sherland Bldg.  
Miller, Milo K.  
122 N. Lafayette Blvd.  
Mott, C. A. 1301½ W. Washington  
Mueller, Hilbert M.  
122 N. Lafayette Blvd.  
Murphy, Eugene C.  
122 N. Lafayette Blvd.  
Murphy, J. F. 625 J.M.S. Bldg.

N-O  
Nelson, F. Dale. 704 N. Main St.  
Nelson, R. E. 206 E. Bartlett St.  
Olson, K. L. 615 Sherland Bldg.

P  
Parmley, Walter E. Jr.  
1342 Mishawaka Ave.  
Parshall, Dale B.  
615 Sherland Bldg.  
Parsons, Robert L.  
424 Odd Fellows Bldg.  
Pauszek, T. B. 726 W. Washington  
Petrass, A. 516 Sherland Bldg.  
PHELPS, Stephen R.  
818 Sherland Bldg.  
Plain, George  
122 N. Lafayette Blvd.  
Potter, Thomas P. Jr.  
531 N. Main St.  
Proudfit, Charles H.  
525 Odd Fellows Bldg.  
Pyle, H. D. 518 Sherland Bldg.

R  
Rasmussen, Ruth F.  
122 N. Lafayette Blvd.  
Rigley, E. L. 408 Sherland Bldg.  
Rodin, H. H. 422 Sherland Bldg.  
Rosenheimer, G. M. 604 N. Main  
Rubens, Eli. 408 Odd Fellows Bldg.  
Rudolph, Carl J.  
110 West Bartlett St.

S  
Sanderson, Robert B.  
730 Sherland Bldg.  
Sandock, I. 402 Sherland Bldg.  
Sandock, Louis F.  
428 Sherland Bldg.  
Sandoz, Harry H.  
615 Odd Fellows Bldg.  
Savery, C. E. 230 Sherland Bldg.  
Schiller, H. A. 226 Sherland Bldg.  
Scott, F. M. 122 N. Lafayette Blvd.  
Selby, Keith E. 407 Lincolnway W.  
Sellers, Francis M.  
1602 E. Wayne

Sensenich, R. L. 203 J.M.S. Bldg.  
Sharp, Merle C.  
120 N. Lafayette Blvd.  
Shelley, Edw. 728 W. Colfax  
Skillern, P. G. 1002 Bldg. & Ln. Tr.  
Slominski, Harry H.  
708 Odd Fellows Bldg.  
Spenner, R. W. 726 Sherland Bldg.  
Staunton, H. A. 3023½ Mishawaka  
Stiver, D. D. 822 Sherland Bldg.  
Stogdill, William J.  
525 Sherland Bldg.  
Stratigos, Joseph S.  
713 E. Jefferson Blvd.  
Szokolay, Joseph P.  
210 Poledor Bldg.



T  
Thompson, John M.  
921 Lincoln Way East  
Thompson, Robert A.  
530 W. Indiana Ave.  
Thornton, M. J. 825 Sherland Bldg.  
Traver, P. C. 1010 Riverside Dr.

V-W  
Vagner, S. Bernard  
234 Birdsell

Vurpillat, Francis J.  
132 N. Lafayette Blvd.  
Wegner, W. G. (S) 616 W. Wash.  
Weiss, Eugene 2521 S. Michigan  
Wilhelm, A. M. 628 Sherland Bldg.  
Wilson, James 409 J.M.S. Bldg.  
Zeiger, Irvin 3201 Mishawaka

Nassef, George J. Walkerton  
Cline, Kenneth L. Wyatt  
Burket, Cecil R.

4301 Dozier's Corner Rd.  
Norfolk, Va.

Ward, James W.  
235 E. 22nd St., Apt. 10e,  
New York, N.Y.

### SCOTT COUNTY

Bogardus, Carl R. Austin  
Hill, Thomas N. Scottsburg  
McClain, Marvin L. Scottsburg  
Napper, Floyd S. Scottsburg

### SHELBY COUNTY

Nigh, Rufus M. Fairland  
Davis, John A. Flat Rock  
Jean, Thomas A. Morristown  
Miller, Frank H. Morristown  
Patten, Vernon C. (S) Morristown

Shelbyville

Barnum, Emerson  
110 E. Hendricks  
Billman, Gustus S. R. R. 2  
Dalton, Wilson L.

301 Methodist Bldg.  
Gehres, Robert W. 15 S. Tompkins  
Inlow, H. H. 103 W. Washington  
Inlow, W. D. 103 W. Washington  
Miller, Richard C. 17 Mechanic  
Richard, N. F. 103 W. Washington  
Scott, V. B. 103 W. Washington  
Silbert, David B. 17 S. Tompkins  
Spindler, Robt. D. 165 W. Mechanic  
Tindall, Paul R. 20 N. Pike  
Tindall, W. R. 505 S. Harrison  
Whitcomb, Roger F.

302 Methodist Bldg.

Coulson, Sewell B. (S) Waldron  
Keeling, James E. (S) Waldron

### SPENCER COUNTY

Barrow, John H. Dale  
Medcalf, Norman L. Lamar  
Atchison, Kenneth C. Rockport  
Buxton, Eva J. (S) Rockport  
Ehrman, C. D. (S) Rockport  
Glackman, John C., Jr. Rockport

### STARKE COUNTY

Leinbach, Earl Hamlet  
DeNaut, James F. Knox  
Henry, Howard S. Knox  
Ingwell, Guy B. Knox  
McClure, Clark Knox

Grant, Albert J. North Judson  
Matthew, J. R. North Judson

### STEBUEN COUNTY

Artz, Richard W. Angola  
Barton, Robert Angola  
Cameron, Mary H. Angola  
Creel, Donald W. Angola  
Crum, Marion M. Angola  
Hartman, John J. Angola  
Kissinger, Knight L. Angola  
Lane, William H. (S) Angola  
Mason, Donald G. Angola  
Rausch, Norman W. Angola  
Geyer, Joseph Ashley  
Blosser, Blaine A. Fremont  
Hippensteele, Ralph O. Fremont  
Alford, James Hamilton  
Schrepferman, Wayne Hamilton  
Denman, Robert D. (S) Helmer

### SULLIVAN COUNTY

Brown, John S. Carlisle  
Whipps, Charles E. Carlisle  
Dukes, Betty Dugger  
Dukes, Frederic M. Dugger  
Dukes, Joe E. Dugger  
Betha, Robert O. Farmersburg  
O'Dell, Harry C. Farmersburg  
Bedwell, Marion H. Sullivan  
Crowder, James H., Jr. Sullivan  
Higbee, Paul Sullivan  
Maple, James B. (S) Sullivan  
Parmenter, Harry Sullivan  
Scott, Garland D. Sullivan  
Scott, Irvin H. Sullivan

### SWITZERLAND COUNTY

(See Jefferson-Switzerland)

### TIPPECANOE COUNTY

Lafayette

Ade, C. H. 2211 South St.  
Ade, Mary K. 2211 South St.  
Arnett, Arett C. 312 N. Eighth  
Balkema, C. M.

623 Lafayette Life Bldg.

Bauer, Arthur J. 112 N. Seventh  
Bayley, William E. Home Hospital  
Beeler, James M.

Wabash Valley Sanitarium

Bolin, Robert C. 24 N. 24th St.  
Buhrmester, Harry C., Jr.

312 N. Eighth  
Burkle, John C. 133 N. Fourth  
Burns, John T. 5 N. 25th St.

Calvert, Raymond R. 314 N. Sixth  
Cole, Ira 2315 South

Cox, Wayne T. 206-7 Schultz Bldg.  
Coyner, Alfred B.

509 Lafayette Life Bldg.

Crockett, Franklin S.  
312 Lafayette Life Bldg.

Dewey, G. W. (S) 122 S. 28th St.  
Dickerson, William M.

2211 South St.

Donahue, George R.  
718 Lafayette Life Bldg.

Dubois, Ramon B. 2211 South St.  
Eaton, M. J.

214 Lafayette Life Bldg.  
Engeler, James E. 308 N. Eighth

Ferguson, Wm. B. 2211 South St.  
Flack, Russell A. 217 N. Sixth

Frasch, M. G. Lafayette Life Bldg.  
Frey, Harley B.

405 Lafayette Life Bldg.

Gery, Richard E. 312 N. Eighth  
Gripe, R. P. 312 N. 8th St.

Harden, Murray  
716 Lafayette Life Bldg.

Harshman, M. L. 312 N. Eighth  
Harter, Eli Blair 312 N. Eighth  
Herrold, George W.

2323 South St.

Holladay, Lloyd J.  
411 Lafayette Life Bldg.

Hughes, Richard 2216 South St.  
Hummell, Paul 2352 N. 25th St.

Hunsberger, W. G. 506 S. 7th St.  
Hunter, F. P. Lafayette Life Bldg.

Johnson, Herbert S. 312 N. 8th St.  
Johnson, Lowell R. 2315 South

Jones, David 24 N. Twenty-fourth  
Karberg, R. J. 420 Columbia St.

Klatch, Ben Z. 2211 South St.  
Klepinger, Harry E.

824 Lafayette Life Bldg.

Laws, H. J.  
411 Lafayette Life Bldg.

Laws, Kenneth F.  
501 Lafayette Life Bldg.

Levering, Guy P. (S)  
819 Central St.

Loop, Floyd A. (S)  
2211 South St.

Loop, F. A.  
601 Lafayette Life Bldg.

McAdams, H. B. 1411 Sunset Dr.  
McAdams, Robert 631 Columbia

McClelland, D. C. 312 N. Eighth  
McFadden, James M.

St. Elizabeth Hosp.

McKinley, Joseph  
312 Lafayette Life Bldg.

McKinney, Daniel H.  
814 Lafayette Life Bldg.

Marsh, G. W. 1405 N. Fourteenth  
Marsh, William L.

St. Elizabeth Hosp.

Miller, Roland E. 1625 Kossuth  
Morrison, John S. (S)

422 N. 7th St.

Neumann, Kenneth O.  
613 Lafayette Life Bldg.

Pearlman, Samuel S. (S)  
107 N. Sixth

Peterson, Joel A.  
609 Lafayette Life Bldg.

Peyton, Frank W. 15 N. 25th  
Ratcliff, Frank W. 300 Main

Rothrock, Philip W. 1625 Kossuth  
Ruschli, Edward B.

510 Lafayette Life Bldg.

Sholty, William M.  
405 Lafayette Life Bldg.

Smith, Lowell C. 405 Schultz Bldg.  
Stahl, Edward T. 312 N. Eighth

Steele, Hugh H. 312 N. 8th St.  
Strayer, Joseph W.

612 Lafayette Life Bldg.

Strickland, Martha B.  
2211 South St.

Thomas, Gordon A. 608 Columbia  
Trout, Carl J. 314 N. Sixth

Tubbs, George R. (S)  
2503 Main St.

VanBuskirk, E. L. 308 N. Eighth  
Vermilya, Robert W.

405 Lafayette Life Bldg.

Washburn, Will W. 312 N. Eighth

Mitchell, Edgar T. Romney  
Babb, Forrest J. Stockwell



**West Lafayette**

Ash, Harold H. . . . . 200 South St.  
 Carroll, Bertha Rose  
     Purdue University  
 Meikle, Louise J. . . . . 606 Terry Lane  
 Miller, Sayers J. . . . . Purdue Univ.  
 Rommel, C. H. . . . . 460 Northwestern  
 Schmiedicke, Paul H. . . . . 325 Vine St.

Martin, Harold G.  
     35922 Jefferson Rd.,  
     Mt. Clemens, Mich.  
 Spurlock, Fae H. . . . . V.A. Hosp.  
     Topeka, Kan.

**TIPTON COUNTY**

Stouder, Albert E. . . . . Kempton  
 Tranter, William F. . . . . Sharpsville  
 Belding, Ray, Jr. . . . . Tipton  
 Burkhardt, Boyd A. . . . . Tipton  
 Carter, Jean V. . . . . Tipton  
 Compton, George . . . . . Tipton  
 Gossard, Meredith B. . . . . Tipton  
 Kincaid, Raymond K. . . . . Tipton  
 Kurtz, William A. . . . . Tipton  
 Warne, George H. . . . . Tipton  
 Ericson, Harold L. . . . . Windfall  
 Moser, Elmer B. (S) . . . . Windfall

**UNION COUNTY**

(See Wayne-Union)

**VANDEBURGH COUNTY****Evansville**

**A**  
 Acre, Robert R. . . . . 706 Walnut  
 Adler, Raymond N. . . . . 714 Second  
 Alexander, John E.  
     609 Hulman Bldg.

Anderson, Milton H.  
     State Hospital  
 Antes, Earl H. . . . . 420 Cherry St.  
 Austin, E. W. . . . . 216 SE Riverside Dr.

**B**  
 Baker, H. M. . . . . 402 Hulman Bldg.  
 Baker, Jas. S. (S)  
     2670 Stringtown Road  
 Baker, Mason R. . . . . 957 S. Ky. Ave.  
 Ballas, William A.  
     Deaconess Hospital

Barclay, Irvin C. . . . . 114 SE Second  
 Barnhart, Willard T. . . . . 527 Sycamore  
 Baylor, Edward M. . . . . 415 S. Lincoln  
 Beck, Robert E. . . . . 600 Mary St.  
 Begley, Joseph W. Jr.  
     314 S.E. Riverside Drive

Bennett, Abner  
     Welborn Baptist Hospital  
 Bissonnette, Roger P.  
     420 Cherry St.

Boswell, R. W. C. . . . . 2509 Wash.  
 Boyd, Stella N. . . . . 502 Hulman Bldg.  
 Britt, Robert . . . . . 420 Cherry St.  
 Brockmole, A. W. . . . . 517 Edgar St.  
 Brown, J. A., Jr. . . . . 605 E. Sixth  
 Bryan, S. L. . . . . 607 Hulman Bldg.  
 Buchholz, R. R. . . . . 420 Cherry St.  
 Buehner, Donald F.  
     2104 Washington Ave.

Buikstra, C. R. . . . . 609 Hulman Bldg.  
 Burnikel, Ray H. . . . . 527 Sycamore St.

**C**

Cacia, John J. . . . . 609 Hulman Bldg.  
 Caldwell, W. C. . . . . 504 Old Nat. Bk.  
 Cheydleur, Eleanor  
     314 S.E. Riverside Dr.

Clements, Albert F.  
     3315 Lincoln Ave.  
 Clouse, Paul A.  
     613 S. Weinbach Ave.  
 Cockrum, W. M. . . . . 908 Hulman Bldg.  
 Cody, Burtis L. . . . . 204 Boehne Bldg.  
 Coleman, Joseph E.  
     216 SE Riverside Dr.

Combs, H. T. . . . . 807 W. Indiana  
 Combs, Jno. H. . . . . 412 SE Fourth  
 Combs, Pearl B. . . . . 1623 Lincoln  
 Corcoran, P. J. V. . . . . 118 S. First  
 Crawford, Jas. H. . . . . 221 Chestnut  
 Crevello, Albert J.

Clearview Hosp., Kratzville Rd.  
 Cullnane, C. W. . . . . 2312 W. Franklin

**D**

Daves, William L.  
     608 Old Nat. Bk. Bldg.

Deems, Myers B.  
     314 SE Riverside Dr.  
 Denzer, Edw. K. . . . . 108 SE Second  
 Denzer, Wm. O. . . . . 108 SE Second  
 Dieckman, H. S. . . . . 1012 Cit. Bk. Bldg.  
 Diefendorf, Charles F. (S)  
     2106B W. Franklin

Dodd, Roberts K.  
     Rt. 6, New Green River Rd.  
 Durkee, Melvin S.  
     403 Citizens Nat. Bk. Bldg.

Dycus, Walter A.  
     319 N. St. Joseph Ave.

Dyer, W. K. . . . . 221 Chestnut St.

**E**

Ehrich, William S.  
     Evansville State Hosp.  
 Eisterhold, J. A. . . . . 314 SE Riverside  
 Engel, Edgar L. . . . . 126 SE Seventh

**F**

Faul, Henry J. . . . . 815 Hulman Bldg.  
 Fenneman, Robert J.  
     609 Hulman Bldg.

Fickas, Dallas . . . . . 619 Mary St.  
 Fisher, Wm. C. . . . . 413 First Ave.  
 Fitz Gerald, Maurice D.  
     St. Mary's Hospital

Fitzsimmons, E. L. . . . . 527 Sycamore  
 Fritsch, Louis E. (S) . . . . 1201 First

**G**

Garland, Edgar A. . . . . 606 S. Weinbach  
 Gaul, L. Edw. . . . . 509 Hulman Bldg.  
 Getty, William H. . . . . 420 Cherry St.  
 Griep, Arthur H. . . . . 420 Cherry St.

**H**

Hammond, R. Case  
     527 Sycamore St.

Hare, Daniel M. . . . . 706 Walnut St.  
 Harris, Loftin . . . . . Boehne Hosp.  
 Hart, L. Paul . . . . . 1436 Lincoln Ave.  
 Hartley, C. A., Jr. . . . . 221 Chestnut  
 Hartz, F. Minton . . . . . 123 SE Second  
 Heard, Albert . . . . . 322 E. Cherry  
 Heinrich, Weston A.  
     314 S.E. Riverside Drive

Hendershot, Eugene L.  
     118 S.E. First St.

Hermayer, Stephen  
     124 S.E. First St.

Herrman, Gordon T.  
     402 Hulman Bldg.

Herzer, Clarence C. . . . . 322 N. Fulton  
 Hobbs, Arthur . . . . . 600 Mary St.  
 Hoopes, Jane M. . . . . 125 SE Second

Huggins, Victor S.  
     601 Citizens Nat. Bk. Bldg.  
 Hyatt, Gilbert T. . . . . 420 Cherry St.

**J**

Johnson, G. C. (S)  
     212 Indiana Bank Bldg.  
 Johnson, Stephen L. . . . . 521 Sycamore

**K**

Kauffman, Harley M. . . . . 219 Walnut  
 Kessler, Robt. B. . . . . 1338 Division St.  
 Keys, Lynn . . . . . 420 Cherry St.  
 Kleindorfer, R. L. . . . . 819 W. Franklin

**L**

Laubscher, Clarence. Kratzville Rd.  
 Lawrence, Jos. C. . . . . 413 First Ave.  
 Leich, Chas. F. . . . . 124 SE First  
 Lindsey, Sherman B.  
     420 Cherry St.

Logan, Jesse R. . . . . 503 First Ave.  
 Lynch, Harold D. . . . . 216 SE Riverside

**M**

McCool, Joe H. . . . . 314 SE Riverside  
 McDonald, Joseph D.  
     4300 Lincoln Ave.

Macer, C. G. . . . . 901 Hulman Bldg.  
 MacKenzie, Pierce . . . . . 126 SE Seventh  
 Mahaffy, John H.  
     Vanderburgh Child Guidance Ctr.

Mason, E. E. . . . . 906 Hulman Bldg.  
 Mehl, Rudolph A. . . . . 752 S. Eighth  
 Meyer, Keith T. . . . . 118 SE First

Miller, Laverne B. . . . . 714 N. Main  
 Miller, Milton . . . . . 15 W. Franklin  
 Miller, Minor . . . . . 201 S.E. Third St.  
 Miller, Robert J. . . . . 1905 Division  
 Mills, Fred E. . . . . Deaconess Hosp.  
 Mino, Raymond W. . . . . 723 Mary St.  
 Mino, Robert A. . . . . 723 Mary St.  
 Moehlenkamp, Charles E.  
     614 N. Governor

Muelchi, A. F. . . . . 518 Hulman Bldg.  
 Murphy, Edw. U.  
     908 Hulman Bldg.

**N**

Nenneker, Henry (S)  
     Harmonyway

Newman, A. E. . . . . 912 Hulman Bldg.  
 Niedermayer, Alfred J.  
     960 Washington Ave.

Nisenbaum, Harold  
     704 Hulman Bldg.

Nonte, Leo R. . . . . 1218 Lincoln Ave.

**O**

Olsen, Robert G. . . . . St. Mary's Hosp.  
 Oppenheimer, Ernst . . . . . 103 SE Second

**P**

Pastor, Julius W. . . . . 713 First Ave.  
 Pollard, Walter S. . . . . 115 SE Second

Porro, Francis W. St. Marys Hosp.  
 Present, Julian . . . . . 113 S.E. Second

Price, Shirley G. . . . . 420 Cherry St.  
 Pugh, Willis . . . . . 413 First

**R**

Raphael, I. J. . . . . 617 Hulman Bldg.  
 Ratcliffe, A. W. . . . . 510 SE First

Ravdin, B. D. . . . . 712 Hulman Bldg.  
 Reich, Clarence E. . . . . 1209 N. Fulton

Reitz, Thos. F. . . . . 700 N. Sixth  
 Ringham, Jarrett  
     401 Chandler Ave.

Rininger, H. C. . . . . 1359 Washington  
 Ritchie, William D.  
     2010 Stringtown Rd.

Ritz, Albert S. . . . . 2605 Lincoln



Robinson, Earle U. 615 Bellemeade  
 Rosenblatt, B. B. 709 Hulman Bldg.  
 Rossow, Russell . . . . . 118 SE First  
 Royster, G. M. . . . . 810 Cit. Bk. Bldg.  
 Royster, R. A. . . . . 810 Cit. Bk. Bldg.  
 Ruddick, H. C. 816 Hulman Bldg.  
 Rusche, Henry J. . . . . 313 W. Iowa

## S

Schirmer, R. H. . . . . 1118 W. Franklin  
 Schneider, Charles P.  
     2211 W. Franklin St.  
 Schriefer, Victor V.  
     1120 N. Main St.  
 Slaughter, H. C. 908 Hulman Bldg.  
 Slaughter, John 101 S.E. Third St.  
 Slaughter, O. L. . . . . 118 E. First  
 Snively, W. D., Jr.

    Mead Johnson & Co.  
 Springstun, Walter R.  
     601 Hulman Bldg.  
 Steckler, Robert J.  
     808 S. Norman Ave.  
 Steele, Paul W.

    1651-B Lincoln Ave.  
 Sterne, John. . . . . 221 Chestnut St.  
 Stork, Urban. . . . . 412 SE Fourth  
 Strueh, Paul E. . . . . 124 S. First St.

## T

Tager, Stephen. . . . . 219 Walnut St.  
 Tilden, Margaret  
     R. R. 13, Box 373-A  
 Tweedall, D. C. . . . . 527 Sycamore St.  
 Tweedall, D. G. . . . . 2114 W. Franklin

## U-V

Viehe, Robt. W. . . . . 207 SE First  
 Visser, John W.  
     805 Old Nat. Bk. Bldg.

## W

Watson, James L.  
     1158 Lincoln Ave.  
 Weber, Edgar H. . . . . 123 SE Second  
 Weiss, Henry G. (S)  
     614 Hulman Bldg.  
 Welborn, Mell B. . . . . 420 Cherry St.  
 Wilhelmus, C. Kenneth  
     115 SE 7th St.

Wilhelmus, Gilbert. . . . . 1028 Wash.  
 Wilhelmus, Wm. M. . . . . R. R. 7  
 Willis, Chas. F. . . . . 1100 S. Bedford  
 Willison, G. W. . . . . 118 SE First  
 Wilson, David . . . . . 517 Mary St.  
 Wilson, J. D. . . . . 517 Sycamore St.  
 Wilson, Ralph . . . . . 517 Mary  
 Woods, Wm. P. (S)  
     5050 Lincoln Ave.

Wynn, J. F. . . . . 906 Hulman Bldg.

## X-Y-Z

Yeck, Charles W. . . . . 115 SE Sixth  
 Young, C. Curtis. 126 SE Seventh  
 Zeps, E. Frances  
     715 W. Columbia St.  
 Zimmerman, Harold. 6 SE Second  
 Zwickel, Ralph E.  
     417 Third & Main Bldg.

Crimm, Paul D.  
     Ohio Bldg., Sidney, Ohio  
 Schaefer, William C.  
     97 Polaris Dr., Hicksville, N.Y.  
 Wolaver, John H. . . . . V.A. Hosp.,  
     Louisville, Ky.  
 Wyatt, Fred H. . . . . 901 Sherman St.  
     Denver, Colo.

## VERMILION COUNTY

(See Parke-Vermillion)

## VIGO COUNTY

Loving, Jury B. . . . . New Goshen  
 DuPuy, Charles M. (S) . . . . . Riley  
 McIntosh, Wilbert . . . . . Riley

## Terre Haute

## A

Alexander, Oliver O.  
     301 Rose Disp. Bldg.  
 Allen, O. T. (S)  
     422 Rose Disp. Bldg.  
 Anderson, W. C. . . . . 2235 Wabash  
 Asbury, W. D. (S)  
     322 Rose Disp. Bldg.  
 Ault, Roy . . . . . Tribune Bldg.

## B

Baldridge, William O.  
     12 Points State Bk. Bldg.  
 Bannon, William G.  
     416 Rose Dispensary Bldg.  
 Blum, Leon L.  
     210 Rose Dispensary Bldg.  
 Bopp, Henry, Jr. . . . . 221 S. Sixth St.  
 Bopp, Henry W. . . . . 132 Barton Ave.  
 Bopp, James . . . . . 2635 Wilson  
 Bradley, Stephen C. 916 S. 25th St.  
 Bronson, Paul J. . . . . 721 Wabash  
 Brown, Robert R. . . . . 221 S. Sixth

## C

Cajacob, Melville E. . . . . 1000 S. Sixth  
 Caldwell, Milton V. . . . . Tribune Bldg.  
 Cavins, Alexander W. 221 S. Sixth  
 Combs, Chas. N. (S) . . . . . 2516 N. Ninth  
 Combs, S. R. . . . . 505 Tribune Bldg.  
 Congleton, George C.  
     308 Merchants Nat. Bk. Bldg.  
 Conklin, J. O. 500 Rose Disp. Bldg.  
 Curry, C. A. . . . . 506 Rose Disp. Bldg.

## D

Davis, Merle J. . . . . 221 S. Sixth St.  
 Decker, Harvey B. . . . . 14 Rea Bldg.  
 Dyer, Geo. W. . . . . 208 Rose Disp. Bldg.

## F

Forsyth, David H. (S)  
     714 S. 8th St.  
 Freed, J. E. . . . . 414 Rose Disp. Bldg.  
 Freed, John E., Jr.  
     414 Rose Disp. Bldg.  
 Fuqua, Harold B. . . . . 1616 N. 9th St.

## G

Gerrish, D. A. . . . . Rose Disp. Bldg.  
 Gilbert, Ivan 505 Rose Disp. Bldg.  
 Gillum, John R. (S) . . . . . 221 S. Sixth  
 Goodman, Hubert T.  
     310 Opera House Bldg.  
 Gossom, Donn R. . . . . Rose Disp. Bldg.

## H

Hamsher, John B.  
     500 Rose Disp. Bldg.  
 Harkness, Robert G.  
     301 Rose Disp. Bldg.  
 Harris, Howard H. . . . . 112 N. 7th St.  
 Haslem, E. R. 401 Rose Disp. Bldg.  
 Haslem, John R. . . . . 221 S. Sixth  
 Hoover, Dewey A. . . . . 14½ N. Third  
 Humphrey, Paul E.  
     322 Rose Disp. Bldg.  
 Hunt, Edgar J. . . . . R. R. 1

## K

Kabel, Robert N. 505 Tribune Bldg.  
 Kriebble, William W. . . . . 221 S. Sixth  
 Kunkler, Joseph . . . . . 408 Chestnut  
 Kunkler, William C.  
     212 Merchants Bk. Bldg.

## L

LaBier, Clarence Rollin (S)  
     1630 Wabash Ave.  
 LaBier, C. R. . . . . 1630 Wabash Ave.  
 Lancet, Robert O. . . . . 2022 Wabash  
 Loewenstein, W. L. 1537 S. 7th St.  
 Luckett, C. L. 211 Fairbanks Bldg.

## M

Lyons, L. Mason . . . . . 123 S. 21st St.  
 McBride, Noel S.  
     407 Merchants Nat. Bk. Bldg.  
 McCormick, Wilbur C.  
     312 Merchants Bk. Bldg.  
 McCrea, Fred R. 416 Tribune Bldg.  
 McEwen, James W.  
     321 Rose Disp. Bldg.

McLaughlin, Gordon C.  
     501 Tribune Bldg.  
 Mahoney, Charles L. . . . . 221 S. Sixth  
 Malone, Leander A. . . . . 721 Wabash  
 Mankin, Wm. J. . . . . 2235 Wabash Ave.  
 Mason, Lester M.  
     312 Merchants Nat. Bk. Bldg.  
 Mattox, Don M. . . . . 721 Wabash  
 Meyn, Werner P. . . . . 221 S. Sixth  
 Miklozek, John E. . . . . 1461 S. Seventh  
 Miller, Daniel B. (S) . . . . . 1603 S. 7th  
 Milesen, Ann L. M. 826 S. 6½ St.  
 Musselman, G. G. 424 Fourth Ave.

## N-O

Nay, Ernest O. . . . . 221 S. Sixth  
 Neudorff, Louis G. 221 S. Sixth St.  
 Oliphant, R. W. 410 Tribune Bldg.

## P

Pearce, Roy V. . . . . 1440 S. 25th St.  
 Pierce, Harold J. . . . . 627 Cherry

## R

Reed, Robert C. 211 Fairbanks Bld.  
 Reynolds, Richard J. . . . . 901 S. 25th  
 Richart, J. V. 414 Rose Disp. Bldg.  
 Riggs, Floyd C. 2228 Wabash Ave.  
 Rubin, Milton M. . . . . 221 S. 19th St.

## S

Sayers, F. E. . . . . R.R. 5, Box 39A  
 Scherb, Burton E. . . . . 104 N. Seventh  
 Schott, Edward J. (S)  
     Merchants Nat. Bk. Bldg.  
 Schumaker, Robert A.  
     211 Fairbanks Bldg.

Selsam, Etta  
     203 Merchants Nat. Bk. Bldg.  
 Shanklin, Vernon A.  
     202 Fairbanks Bldg.  
 Shapiro, Burton J. . . . . 924 N. 19th St.  
 Showalter, J. R. . . . . 1255½ Maple Rd.  
 Siebenmorgen, L. . . . . 1200 S. Eighth  
 Siebenmorgen, P. . . . . 1200 S. Eighth  
 Silverman, N. M. . . . . 1634 S. Seventh  
 Sloss, Imit H. . . . . 1029 S. Seventh  
 Smoots, S. A. . . . . 1307 Maple Ave.  
 Solomon, Robert D.  
     Rose Disp. Bldg.

Speas, R. C. . . . . 402 Tribune Bldg.  
 Spigler, James F.  
     1402 Wabash Ave.  
 Stewart, Walter E. . . . . 721 Wabash  
 Stoelting, J. L. 507 Rose Disp. Bldg.  
 Strecker, Wm. L. . . . . 100 S. 25th St.  
 Strong, Daniel S. (S)  
     R. R. 7, Box 170

Sullivan, John M.  
     2242 College Ave.

## T

Topping, M. C. . . . . 505 Tribune Bldg.



U-V  
 Utterback, Arnold  
 R. R. 2, West Terre Haute  
 VanArsdall, C. R. .... 17 S. Ninth  
 Voges, Edward C. .... 1402 Wabash

W  
 Weber, Joseph G. S. .... 721 Wabash  
 White, Jas. V. .... Tribune Bldg.  
 Wiedemann, Frank E. (S)  
 222 Rose Disp. Bldg.  
 Wilson, Fred L. .... 1501 S. Third  
 Wyeth, Chas. (S) .... 1100 S. 7th

X-Y-Z  
 Zwerner, Paul F.  
 12 Points State Bk. Bldg.

Wilkerson, Edward L.  
 17th Army Eng. Bn.,  
 A.P.O. 42, New York, N. Y.

### WABASH COUNTY

McKay, Robert D. .... LaFontaine  
 Walker, James L. .... LaFontaine  
 Balsbaugh, Geo. .... N. Manchester  
 Brubaker, O. G. (S)

N. Manchester  
 Bunker, L. Z. .... N. Manchester  
 Cook, Chas. E. .... N. Manchester  
 Seward, Geo. W. .... N. Manchester  
 Venable, Geo. L. .... N. Manchester  
 Warvel, Joseph L. (S)

N. Manchester  
 Kidd, James G. .... Roann

Wabash  
 Black, Edgar K. .... 209 W. Main  
 Dannacher, Wm. D.

284 N. Wabash  
 Elward, Carl J. .... 290 N. Wabash  
 LaSalle, Robert M. .... 55 W. Market  
 Matteucci, Walter V.

284 N. Wabash  
 Mills, John F. .... 24 E. Main  
 Pearson, William E. .... 290 N. Wabash  
 Rhamy, Arthur P. .... 671 N. East  
 Steffen, Arthur J. .... 70 W. Hill  
 Steffen, Julius T. .... 443 N. Wabash  
 Stoops, Jean T. .... 284 N. Wabash  
 Wall, Joseph A.

New Bradley Bldg.  
 Whisler, Frederick M. .... 10 W. Hill  
 Jewett, Laurence (S)

407 Concourse,  
 Excelsior Springs, Mo.

### WARREN COUNTY

(See Fountain-Warren)

### WARRICK COUNTY

Dimmett, Robert .... Boonville  
 Hoover, Peter B. .... Boonville  
 Purcell, Jack H. .... Boonville  
 Rudolph, Kenneth .... Boonville  
 Samples, John T. (S) .... Boonville  
 Stover, Wendell C. .... Boonville  
 Wilson, Paul E. .... Boonville  
 Younan, Tom .... Boonville  
 Gill, Bernard P. .... Chandler  
 Taylor, Lon S. .... Elberfeld  
 Faith, Ira L. .... Newburgh  
 Rogers, Arthur .... Newburgh  
 Wilhelmus, Charles M. .... Newburgh

### WASHINGTON COUNTY

Tower, Thomas K. .... Campbellsburg  
 Green, William L. (S) .... Pekin  
 Paynter, William .... Pekin

Apple, Eddie. .... Salem  
 Episcopo, A. R. .... Salem  
 Gilliatt, James P. .... Salem  
 Huckleberry, Irvin E. .... Salem  
 Mull, Philip L. (S)  
 Bluegrass Hotel, Louisville, Ky.

### WAYNE-UNION COUNTIES

Clark, Marion E. .... Cambridge City  
 Hill, Paul G. .... Cambridge City  
 Kenyon, Charles E. .... Cambridge City  
 Barton, Willoughby M. .... Centerville  
 Hutchison, Donald R. .... Fountain City  
 Zimmerman, Wm. H. .... Dublin  
 Marsh, Chester A. .... Hagerstown  
 Miller, William A. .... Hagerstown  
 Newnum, Raymond L. .... Hagerstown  
 Dubois, Franklin T. (S) .... Liberty  
 Lewis, James F. .... Liberty  
 McWilliams, William B. .... Liberty  
 Thompson, Will A. (S) .... Liberty  
 Denny, Edgar C. .... Milton

#### Richmond

Adney, Frank B.  
 306 Medical Arts Bldg.  
 Ake, Loren  
 410 First Nat. Bk. Bldg.  
 Allen, Hubert E. .... 21 S. Eighth  
 Allen, Robert T. .... 21 S. Eighth  
 Ballenger, William E.  
 309 Med. Arts Bldg.  
 Blossom, Paul W. .... 825 S. A St.  
 Bond, Charles S. (S) .... 112 N. 10th  
 Buche, Fredk. P. .... 106 S. Seventh  
 Campbell, Perry A.  
 422 Med. Arts Bldg.

Coble, Frank H. .... 51 S. Eighth  
 Cook, Norman R.  
 428 Medical Arts Bldg.

Cox, Leon T. .... 36 S. Eighth  
 Daggy, James R. .... 35 S. 8th St.  
 Dingle, P. E. .... 403 Med. Arts Bldg.  
 Ebbinghouse, Tom. .... 98 W. Main  
 Ewbank, J. Nelson

Smith-Esteb Hosp.  
 Griffis, V. C. .... 208 Med. Arts Bldg.  
 Hadley, Harvey (S)

1st Nat'l. Bank Bldg.  
 Harmon, C. J. .... 407 Med. Arts Bldg.  
 Hays, George R. (S)

401 Second Nat. Bk. Bldg.  
 Herring, George N.

Richmond State Hospital  
 Hill, Gladys Marie  
 407 Medical Arts Bldg.

Hill, H. D. .... 412 Med. Arts Bldg.  
 Hunt, G. J. .... Reid Memorial Hosp.  
 Johnson, George M.

403 Medical Arts Bldg.  
 Johnson, P. S. (S)

215 Med. Arts Bldg.  
 Kime, Charles E. .... 501 S. 19th St.  
 Krueger, Fredk. W. (S)

45 S. Seventh  
 Laird, Leslie A. .... Rich. St. Hosp.  
 Lee, G. W. .... 139 Med. Arts Bldg.

Ling, John F. .... 130 Med. Arts Bldg.  
 Logan, James Z.

303 Second Nat. Bk. Bldg.  
 Loomis, Charles H.

Medical Arts Bldg.  
 Mader, John H. .... 808 South A  
 Malcolm, R. .... 127 Med. Arts Bldg.

Meredith, Elwood J.  
 203 Med. Arts Bldg.

Park, Byron J. .... 300 S.W. 5th  
 Passino, James. .... Reid Mem. Hosp.  
 Ramsdell, Glen A. .... 1020 Peacock  
 Ross, Harry P.

410 Second Nat. Bk. Bldg.  
 Ross, James S. .... 321 S. 14th St.  
 Runge, Paul W. .... 1426 E. Main  
 Sage, Charles V. .... 47 S. Eleventh  
 Shields Tom S. .... 47 S. Eleventh  
 Smith, John R. .... 510 S. A St.  
 Snyder, M. C. .... 130 Med. Arts Bldg.  
 Stamper, L. A. .... 402 Med. Arts Bldg.  
 Stepleton, J. D. .... Reid Mem. Hosp.

Stillwell, William R.  
 21½ S. 8th St.  
 Sweet, H. E. .... 35 S. 8th St.  
 Taylor, W. R. .... 308 Med. Arts Bldg.  
 Vance, W. C. .... 136 Med. Arts Bldg.  
 Wanninger, Horace

408 Second Nat. Bk. Bldg.  
 Warrick, Francis B. .... 1426 E. Main  
 Weinstein, E. B. .... 204 Colonial Bldg.  
 Wertenberger, Morris D.

Reid Mem. Hosp.  
 Whallon, Arthur J. .... 29 S. Tenth  
 Wisener, G. H. .... 213 Med. Arts Bldg.  
 Yencer, Martin W. (S) .... 22 N. 14th

Heck, Rolfe A. .... College Corner, O.  
 Shepard, Fred F.

College Corner, Ohio  
 Faulkner, W. H.

Meharry Med. Col.,  
 Nashville, Tenn.

### WELLS COUNTY

#### Bluffton

Annis, Homer B. .... 303 S. Main  
 Aucreman, Charles J. .... 303 S. Main  
 Brickley, Harry D. .... 227 S. Main  
 Buckner, Joy F. .... 116 E. Walnut St.  
 Caylor, Harold D. .... 303 S. Main  
 Caylor, T. E. .... 303 S. Main  
 Cook, Robert G. .... 303 S. Main  
 Dorrance, Thos. O. .... 303 S. Main  
 Eisaman, Jack L. .... 303 S. Main  
 Gillette, Walter R. .... 303 S. Main St.  
 Gitlin, Max M. .... 121½ E. Market  
 Gitlin, William A. .... 121 E. Market  
 Hamilton, O. G. .... 227 S. Main  
 Jackson, Charles E. .... 303 S. Main  
 Johnston, Robert L. .... 303 S. Main  
 Kephart, S. Bruce. .... 303 S. Main  
 Mead, Clarence H. .... 227 S. Main  
 Nickel, Allen. .... 303 S. Main  
 Phillips, John F. .... 303 S. Main  
 Savory, Paul B. .... 303 S. Main  
 Shively, John A. .... 303 S. Main St.  
 Talbert, Pierre C. .... 303 S. Main  
 Tirman, Wallace S. .... 303 S. Main  
 Yoder, Richard P. .... 303 S. Main

Gingerick, C. M. .... Liberty Center  
 Davidoff, Manuel A. .... Ossian  
 Hardin, Wayne E. .... Ossian

### WHITE COUNTY

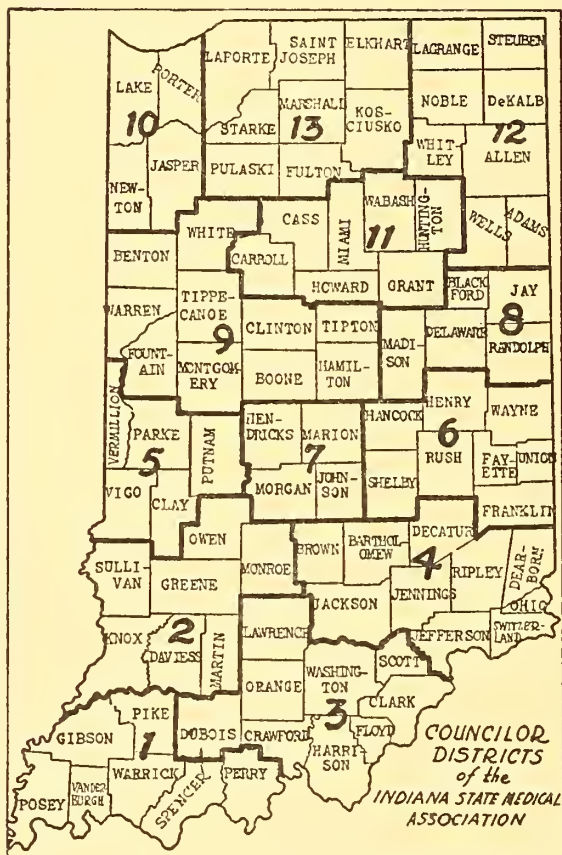
Galbreth, Jesse P. (S)  
 Burnettsville  
 Derhammer, George L. .... Brookston  
 Gish, Howard M. .... Brookston  
 Netherton, Clyde R. .... Chalmers  
 Houser, Wayne W. .... Monon  
 McClure, Stanley E. .... Monon  
 Beck, David C. .... Monticello

Carney, John C. .... Monticello  
 Geist, H. W. (S) .... Monticello  
 Hibner, Nolan .... Monticello  
 Morris, Warren V. .... Monticello  
 Mayfield, Clifford H. (S) Reynolds  
 Baynes, Frank L. .... Wolcott  
 Forbes, Violet M. Crabbe.. Wolcott

### WHITLEY COUNTY

Hershey, Ernest A. .... Churubusco  
 Minick, Linus .... Churubusco  
 Bowman, Ralph F. .. Columbia City  
 Hamilton, Thomas.. Columbia City

Heritier, Claude J. .. Columbia City  
 Kratz, Paul E. .... Columbia City  
 Langohr, John .... Columbia City  
 Lehmberg, Otto F. .. Columbia City  
 Nolt, Ernest V. .... Columbia City  
 Thompson, Frank ... Columbia City  
 Huffman, Verlin P. .. South Whitley





# WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

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VICE-PRESIDENT .....	Mrs. T. R. Hayes	920 W. North	Muncie
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FOURTH			
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CORRESPONDING			
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TREASURER .....	Mrs. John M. Sullivan	2242 College Ave.	Terre Haute
PARLIAMENTARIAN .....	Mrs. Charles F. Voyles	4150 N. Meridian St.	Indianapolis
HISTORIAN .....	Mrs. Philip W. Rothrock	2061 S. 9th St.	Lafayette

## COMMITTEE CHAIRMEN

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EDITORIAL .....	Mrs. Frank Green	516 N. Morgan St.	Rushville
BULLETIN .....	Mrs. George R. Bloom	130 Glendale Ave.	Elkhart
CIVIL DEFENSE .....	Mrs. Kenneth Brown	1654 Hedden Park	New Albany
FINANCE .....	Mrs. Milton Gevirtz	6528 Forest Ave.	Hammond
LEGISLATION .....	Mrs. C. W. Dahling	Doyle Road	New Haven
TODAY'S HEALTH .....	Mrs. Paul W. Sparks	601 W. Will	Winchester
PUBLICITY .....	Mrs. Frank Gastineau	5344 N. Pennsylvania	Indianapolis
PROGRAM .....	Mrs. Walter L. Portteus	R. R. 2, Box 11 B	Franklin
RURAL AND SCHOOL			
HEALTH .....	Mrs. Robert Evans		Russiaville
PUBLIC RELATIONS .....	Mrs. Hubert T. Goodman	328 Potomac Ave.	Terre Haute
NURSE RECRUITMENT .....	Mrs. J. D. McDonald	4300 Lincoln Avenue	Evansville
AMERICAN MEDICAL			
EDUCATION			
FOUNDATION .....	Mrs. Francis M. Fargher	Pottawattomie Park	Michigan City

## MEMBERSHIP ROSTER—BY COUNTIES

### ADAMS COUNTY

#### Berne

Beaver, Mrs. N. E. 365 N. Harrison  
Bose, Mrs. Robert L. Lehman St.  
Lehman, Mrs. Harold B. Franklin

#### Decatur

Burk, Mrs. J. M. 221 S. Third  
Carroll, Mrs. J. C. R. R. 4  
Girod, Mrs. A. H. 1004 W. Monroe  
Kohue, Mrs. G. J. 304 W. Adams  
Parrish, Mrs. Richard  
238 S. Second  
Rayl, Mrs. C. C. 334 S. First  
Reppert, Mrs. R. L. Road No. 224  
Terveer, Mrs. John B.  
415 W. Madison  
Zwick, Mrs. H. F. 401 E. Rugg

#### Geneva

Schetgen, Mrs. J. V. Box 236

### ALLEN COUNTY

#### Bluffton

Brickley, Mrs. Harry D.  
227 S. Main  
Buckner, Mrs. J. 116 E. Walnut  
Hamilton, Mrs. O. G. 203 E. Central  
Mead, Mrs. C. H.  
221 W. Washington

#### Fort Wayne

A  
Adams, Mrs. J. R.  
2538 Fairfield Vw. Pl.  
Aiken Mrs. A. F. 1927 E. State

Aiken, Mrs. N. E. 1923 E. State  
Aldrich, Mrs. Harry  
2710 Broadway

#### B

Bailey, Mrs. Paul. 1840 Pemberton  
Baltes, Mrs. J. H. 4816 Beaver Ave.  
Bash, Mrs. W. E.  
1201 Korte Lane  
Beams, Mrs. Ralph  
3710 Wawonaissa  
Beierlein, Mrs. Karl M.  
Butler Road  
Bergendohl, Mrs. Emil  
4225 Tacoma  
Beutler, Mrs. Theodore V.  
4506 Standish Drive  
Blosser, Mrs. H. V.  
1122 W. Washington  
Bolman, Mrs. R. M.  
4135 S. Harrison

Bonner, Mrs. Joseph  
310 E. Washington  
Borders, Mrs. Theodore  
1145 S. Lafayette  
Bowers, Mrs. G. T.  
2609 East Drive  
Bowers, Mrs. J. W.  
817 E. Washington Blvd.  
Brown, Mrs. Frederic  
4129 S. Harrison  
Bruggeman, Mrs. H. O.  
1202 W. Washington  
Bryan, Mrs. Franklin A.  
1439 Edgewater  
Buckner, Mrs. Doster Bass Road

Buckner, Mrs. George D.  
1220 Kensington  
Bulson, Mrs. E. L. 4301 Pembroke

#### C

Calvin, Dr. Jessie C. 312 W. Wayne  
Cameron, Mrs. D. F.  
2724 N. Clinton  
Carlo, Mrs. Ernest. 4633 Crestwood  
Cartwright, Mrs. E. L.  
529 W. Packard  
Catlett, Mrs. M. B. 1143 W. Rudisill  
Clark, Mrs. Wm. 4002 S. Harrison  
Cochran, Mrs. H. A., Jr.  
4811 S. Wayne  
Cooney, Mrs. Charles  
1168 Westover Road  
Culp, Mrs. John E.  
3625 S. Harrison

#### D

Dancer, Mrs. Charles  
905 Columbia Ave.  
Datzman, Mrs. Richard C.  
5402 Bluffton Rd.  
Dunstone, Mrs. H. C. 4134 Indiana

#### E

Eberly, Mrs. Karl C.  
1240 W. Rudisill  
English, Mrs. C. H. 2509 Webster  
Estlick, Mrs. Richard E.  
4223 Beaver

#### F

Ferguson, Mrs. Arthur N.  
4445 Pembroke Lane  
Foy, Mrs. H. W. 1816 Forest Park

## (Fort Wayne—Continued)

G  
Garton, Mrs. Harry W.  
Hamilton Road, R. R. 6  
Gerding, Mrs. Wm. J.  
1721 Forest Park  
Glock, Mrs. Maurice E.  
1913 Forest Park Blvd.  
Glock, Mrs. Wayne . . . R. R. 2  
Goebel, Mrs. Carl W. 4815 Tacoma  
Graham, Mrs. George M.  
1126 W. Rudisill  
Griest, Mrs. Walter D.  
4809 Arlington

H  
Haffner, Mrs. Herman G.  
3606 Mulberry Rd.  
Haller, Mrs. Robert  
828 Kinnaird  
Hamilton, Mrs. Emory D.  
2405 Florida Dr.  
Harvey, Mrs. Harry 2228 Crescent  
Hasewinkle, Mrs. A. M.  
3544 Kirkland  
Hastings, Mrs. Warren C.  
1822 Kensington  
Hattendorf, Mrs. A. P.  
4041 Old Mill Rd.  
Havens, Mrs. Russell E.  
1845 Kensington  
Hoffman, Mrs. Arthur F.  
4223 Indiana  
Hoffmann, Mrs. S. P.  
234 E. Maple Grove  
Holsinger, Mrs. Robert E.  
4617 Indiana

J  
Jackson, Mrs. John F.  
414 W. Rudisill  
Johnson, Mrs. Richard M.  
2516 East Drive  
Jurgensen, Mrs. Walter  
1307 E. Rudisill

K  
Karol, Mrs. Herbert J.  
4507 Kenilworth  
Kaufman, Mrs. Julian  
1724 Crescent  
Keck, Mrs. Carleton A.  
4818 S. Anthony  
Keller, Mrs. Foster C.  
1810 Kentucky  
Kent, Mrs. Richard N.  
2717 East Dr.  
Kidder, Mrs. O. T. . . . Lima Rd.  
Kimbrough, Mrs. Robert  
4601 Beaver  
Kleifgen, Mrs. W. A. 4602 Tacoma  
Kruse, Mrs. Edward  
4001 Old Mill Rd.

L  
Ladig, Mrs. Donald S.  
2720 Fairfield  
Land, Mrs. Francis L.  
4615 S. Anthony  
Lehner, Mrs. John . . . 1119 Maxine  
Leming, Mrs. Ben L.  
3005 N. Anthony  
Lill, Mrs. L. C. . . . 4221 Buell  
Lloyd, Mrs. Robert P.  
3609 S. Anthony  
Lohman, Mrs. Robert M.  
2138 Owaissa  
Lorman, Mrs. James G.  
3901 Kirkwood

Loudermilk, Mrs. J. L.  
1723 Pemberton  
Lyon, Mrs. Wm. C.  
2401 Indian Village

M  
McArdle, Mrs. Edward G.  
1133 Rudisill Blvd.  
McBride, Mrs. W. O.  
610 Beechwood Circle  
McCallister, Mrs. John W.  
4215 Drury Lane  
McCoy, Mrs. Roy R.  
4101 S. Harrison  
McDowell, Mrs. G. A.  
2322 Forest Park Blvd.  
McEachern, Mrs. Cecil  
4705 Indiana  
McFall, Mrs. J. S. . . 3322 Garland  
McKeeman, Mrs. D. H.  
1615 Ardmore  
Mackel, Mrs. F. O. . 1610 Nuttman  
Manning, Mrs. George  
4117 S. Anthony  
Marshall, Mrs. Caesar L.  
1215 McCulloch  
Mensch, Mrs. James R.  
4826 S. Anthony  
Mercer, Mrs. S. R.  
3235 W. Washington  
Meyer, Mrs. T. O. . 4438 Wilmette  
Michaelis, Mrs. S. C.  
1255 Korte Lane  
Miller, Mrs. Carl 457 Oakdale Dr.  
Miller, Mrs. H. Paul  
6408 S. Calhoun  
Miller, Mrs. Mahlon . . 1115 Illsley  
Miller, Mrs. Orval J.  
1102 Kensington  
Miller, Mrs. Richard  
1322 W. Foster  
Moats, Mrs. Carl  
3210 N. Washington  
Moats, Mrs. George  
2107 Kensington  
Moeller, Mrs. Victor 1244 Branning  
Moravec, Mrs. Arthur  
4711 Old Mill Rd.  
Mortenson, Mrs. Leland J.  
1310 N. Foster Parkway  
Mueller, Mrs. Lawrence  
3423 S. Washington Rd.

N-O  
Nahrwold, Mrs. E. W.  
3314 Irvington  
Nill, Mrs. John . . 440 W. Fleming  
Oyer, Mrs. J. H. . . 2206 Wawonissa

P  
Painter, Mrs. Donald  
Washington Center Rd.  
Parker, Mrs. C. B.  
2215 Paulding Rd.  
Perrin, Mrs. Kermit . . . 2828 Lake  
Perry, Mrs. Frederic G.  
709 Kinnaird  
Pickett, Mrs. Merle E.  
2309 Florida Dr.  
Ponczek, Mrs. Edward J.  
3930 Indiana  
Popp, Mrs. Milton F. 3148 Parnell

R  
Ranke, Mrs. Henry . . 3112 Beaver  
Ray, Mrs. Herbert  
325 E. Creighton  
Rhamy, Mrs. B. W. . . 4312 Beaver

Rissing, Mrs. Walter  
3200 Irvington  
Rockey, Mrs. N. A.  
2411 Florida Dr.  
Rodriguez, Mrs. Juan  
4720 Crestwood Dr.  
Roser, Mrs. Arthur . . Leesburg Rd.  
Rossiter, Mrs. D. L.  
724 Oakdale Dr.  
Rothberg, Mrs. Maurice  
4319 Hartman Road  
Rothschild, Mrs. Charles J.  
3015 N. Anthony

S  
Salon, Mrs. Harry  
4017 Hiawatha Blvd.  
Salon, Mrs. N. L.  
Scottswood Ct., R. R. 6  
Sarver, Mrs. Francis E.  
4629 Tacoma  
Savage, Mrs. Robert  
1602 Fairhill Rd.  
Schellhouse, Mrs. Earl M.  
3610 Mulberry Road  
Schlademan, Mrs. K. R.  
4029 Weisser Park  
Schlegel, Mrs. Edward  
2219 N. Anthony Blvd.  
Schmidt, Mrs. Eugene E.  
103 E. Fleming  
Schneider, Mrs. Louis A.  
1351 W. Sherwood  
Schoen, Mrs. Fred 450 Arcadia Ct.  
Scoins, Mrs. W. H. . . 4301 Taylor  
Scott, Mrs. H. Vaughn  
5224 Fairfield  
Senseny, Mrs. Eugene F.  
730 W. Oakdale  
Sherwood, Mrs. Clarence  
Lima Rd., Irene Byron San.  
Sherwood, Mrs. J. V.  
Lima Rd., Irene Byron San.  
Shinabery, Mrs. Lawrence  
1850 Broadway  
Singer, Mrs. Elmer  
825 Oakdale Dr.  
Smith, Mrs. Phillip L.  
3008 S. Lafayette  
Snyderman, Mrs. S. C.  
3222 N. Washington Rd.  
Somers, Mrs. G. H.  
527 W. Fleming  
Stauffer, Mrs. Richard  
4120 S. Harrison  
Stellner, Mrs. Howard A.  
4134 S. Calhoun  
Stier, Mrs. Paul . . . 3807 Fairfield

T  
Terrill, Mrs. Richard  
4727 Old Mill Rd.  
Thornton, Mrs. W. E.  
601 Oakdale Dr.

V  
Van Buskirk, Mrs. E. W.  
920 Maxine Dr.

W  
Warfield, Mrs. C. H.  
1809 Kensington  
Weber, Mrs. John R.  
1215 Sheridan Court  
Wilkins, Mrs. Robert  
4839 Old Mill Rd.  
Williams, Dr. Bernice  
3526 N. Washington Rd.  
Wilson, Mrs. Leslie 2810 S. Wayne  
Wright, Mrs. William  
1834 Pemberton Dr.



**(Fort Wayne—Continued)****Z**

Zweig, Mrs. Elmer... 3365 Garland

**New Haven**

Dahling, Mrs. C. W... 1206 Powers  
 Hoetzer, Mrs. E. M... R. R. 2  
 Smith, Mrs. G. A... Lincoln Highway  
 Stumpf, Mrs. E. E.

Davidoff, Mrs. Manuel A... Ossian  
 Emme, Mrs. Richard W.  
 R. R. 1, Grabill

**BARTHOLOMEW-BROWN COUNTIES****Columbus**

Davis, Mrs. Marvin R.  
 2228 Lafayette  
 Echsner, Mrs. Herman  
 1903 Beam Road  
 Fisher, Mrs. Walter S.  
 906 Franklin  
 Hart, Mrs. Robert B... 1203 16th  
 Hawes, Mrs. Marvin R.  
 2975 Franklin Dr.  
 Henry, Mrs. Alvin L.  
 1913 Chestnut  
 Krueger, Mrs. Robert... Griffa Ave.  
 Marr, Mrs. Griffith... 1513 17th  
 McCullough, Mrs. Henry  
 Old Indianapolis Road  
 Mohler, Mrs. Floyd  
 2104 Gilmore Street  
 O'Bryan, Mrs. Richard  
 1602 Washington  
 Overshimer, Mrs. Lyman  
 1715 Franklin  
 Reid, Mrs. Robert  
 2227 Pennsylvania  
 Ritteman, Mrs. George W.  
 2209 Caldwell Dr.  
 Rothring, Mrs. Howard E.  
 2226 Pearl  
 Ryan, Mrs. Wm. J... 2244 Pearl  
 Schmitt, Mrs. R. K.  
 2639 Riverside Dr.  
 Smith, Mrs. Donald C.  
 1629 Franklin St.  
 Williams, Mrs. E. W. 1902 Franklin  
 Zaring, Mrs. Byron K.  
 2419 Riverside

Dudding, Mrs. Joseph E... Hope

**BENTON COUNTY**

Taylor, Mrs. W. H... Ambia  
 Atkinson, Mrs. C. W... Boswell  
 Leak, Mrs. Robert... Boswell  
 Coddens, Mrs. A. L... Earl Park  
 Miller, Mrs. Dan T... Fowler, Ind.  
 Scheurich, Mrs. Virgil... Oxford  
 Rutherford, Mrs. C.

Otterbein, Ind.

**BOONE COUNTY**

Schaaf, Mrs. Alvin... Jamestown

**Lebanon**

Ballard, Mrs. Robert

Country Club Park

Coons, Mrs. John

Country Club Park

Coons, Mrs. Ritchie... 1617 Park Dr.

Headley, Mrs. Lloyd

Country Club Park

Honan, Mrs. Paul

Elmwood Addition

Kern, Mrs. Clarence... 423 E. Main

Spieth, Mrs. William

Country Club Park

Weddle, Mrs. Charles. 1210 N. East

Wiseheart, Mrs. Robert

Country Club Park

Gregg, Mrs. Edwin... Thorntown

Lovett, Mrs. Harvey... Whitestown

Bailey, Mrs. Lawrence... Zionsville

Harvey, Mrs. Ralph... Zionsville

**CARROLL COUNTY**

Van Kirk, Mrs. John... Burlington

**Delphi**

Crampton, Mrs. Chas.

218 East Monroe

Maggart, Mrs. Ralph... R. R. 3

Seese, Mrs. Robert M.

201 W. North St.

Wagoner, Mrs. John

211 W. North St.

Wagoner, Mrs. Geo. W.

305 W. Summit St.

Adams, Mrs. Max... Box 67, Flora

McLaughlin, Mrs. James

511 East Main St.

**CASS COUNTY****Logansport**

Adamski, Mrs. M. S... 614 17th

Bailey, Mrs. Earl W... 2522 North

Ballard, Mrs. Charles A... R. R. 4

Bradfield, Mrs. John

High Street Road

Cooper, Mrs. Thomas L.

2104 North

Davis, Mrs. John... 2119 North

Fitzgerald, Mrs. Brice... 1930 High

Hall, Mrs. Bernard R.

1707 E. Broadway

Hedde, Mrs. E. L... R. R. 5

Hillis, Mrs. L. J. 2508 E. Broadway

Holloway, Mrs. W. A.

200 Eel River

Holmes, Mrs. Will W.

High Street Road

Jewell, Mrs. E. B.

3019 S. Pennsylvania

Jones, Mrs. J. Carl... R. R. 3

Morrical, Mrs. R. J... 415 Highland

Schenk, Mrs. Foss... 97 21st St.

Shultz, Mrs. Harry... 412½ Fourth

Viney, Mrs. Charles

26th and High St.

Wilson, Mrs. Paul... R. R. 5

Winter, Mrs. Donald K.

2541 E. Broadway

Newcomb, Mrs. W. K.

Royal Center

Flanagan, Mrs. E. P... Walton

Lybrook, Mrs. D. E.

Young America

**CLARK COUNTY****Charlestown**

Buckman, Mrs. Robert J.

32 River Ridge

Duffield, Mrs. John Richard

Monroe Street

Eckles, Mrs. Donald... River Ridge

Goodman, Mrs. Eli... 802 Market

Patterson, Mrs. Cecil L.

1415 Tunnel Mill Rd.

Wolverton, George M.

117 N. Randolph, Clarksville

Greene, Mrs. Wm. R... Henryville

**Jeffersonville**

Adair, Mrs. Sam

R. R. 1, Utica Pike

Buehler, Mrs. George

705 Meigs Ave.

Carlberg, Mrs. Dale L.

2 Blanchel Terrace

Carney, Mrs. J. T.

2602 Hollywood Dr.

Clark, Mrs. Wm. B. Jr.

21 Blanchel Terrace

Dare, Mrs. Lee... 215 Sparks

Graham, Mrs. O. P... 713 E. Maple

Havens, Mrs. Alfred Lyle

203 Sparks

Huoni, Mrs. John S.

6 Blanchel Terrace

Isler, Mrs. Nathaniel

901 Morningside Dr.

Roby, Mrs. A. L.

2709 Hollywood Dr.

Weems, Mrs. Mallory P.

Hopkins Lane

Witt, Mrs. W. R... Oak Park

**Sellersburg**

Regan, Mrs. George L.

Sturgis, Mrs. Donald G.

Vandevent, Mrs. Arthur

**CLAY COUNTY****Brazil**

Maurer, Mrs. J. Frank... 6 E. Park

Maurer, Mrs. Robert M.

1115 N. Meridian

Palm, Mrs. John M... 27 E. Church

Weaver, Mrs. Timothy M... R. R. 2

Webster, Mrs. Robert K.

25 N. Beech

Wood, Mrs. Opal L... 428 E. Blaine

**Clay City**

Bond, Mrs. Walter C.

8th and White

Glosson, Mrs. Jack R.

316 N. Main

Moon, Mrs. Charles E.

Center Point

Ward, Mrs. H. H... Coalmont

**DAVISS-MARTIN COUNTIES**

Chattin, Mrs. Robt... Loogootee

Gootee, Mrs. Hugh... Loogootee

Lett, Mrs. E. B... Loogootee

McCracken, Mrs. J. O. Montgomery

Coleman, Mrs. H. G... Odon

Maschmeyer, Mrs. Robt... Shoals

**Washington**

Blazey, Mrs. A. G... 7 E. Walnut

Burruss, Mrs. B. O... Pine Court

Chattin, Mrs. Vance... Green Acres

Farris, Mrs. John... 411 William

Fox, Mrs. Philip... Green Acres

Lindsay, Mrs. H. B.

1108 Bedford Road

Lloyd, Mrs. C. A... 107 N. E. 2nd

McKittrick, Mrs. Jack. Green Acres

McKittrick, Mrs. W. O.

Green Acres



**(Washington—Continued)**

McNaughton, Mrs. L. M.  
812 E. Main  
Norton, Mrs. Horace... 511 Hefron  
Rang, Mrs. Arthur... 211 E. Ninth  
Rang, Mrs. Robert... 214 E. Ninth  
Seat, Mrs. Marshall  
N. W. 1st Street  
Schroeder, Mrs. Roland... N. E. 1st  
Shields, Mrs. Harry  
1210 Bedford Road  
Smoot, Mrs. Brayton... Troy Rd.  
Schafer, Mrs. Wm. C.  
221 N. E. 9th

**DEARBORN-OHIO  
COUNTIES**

**Aurora**  
Baker, Mrs. Leslie M... 204 Fifth  
Olcott, Mrs. Charles W.  
422 Sunnyside  
Stewart, Mrs. Omer H.  
Second and Bridgeway  
Treon, Mrs. James F. 505 Fifth St.  
**Dillsboro**  
McNeeley, Mrs. Matthew J.  
Elliott, Mrs. John C... Guilford  
**Lawrenceburg**  
Fagely, Mrs. William J.  
57 Oakley  
Houston, Mrs. Fred D... Miller Ave.  
Pfeifer, Mrs. James M. 550 Ludlow  
Streck, Mrs. Francis A. Ridge Ave.  
Vail, Mrs. George A... Ludlow  
**Rising Sun**  
Fessler, Mrs. Gordon  
Manley, Mrs. Charles N.

**DECATUR COUNTY**

Tremain, Mrs. M. A... Adams  
**Greensburg**  
Acher, Mrs. Robert P.  
446 E. Washington  
Blemker, Mrs. Russell  
332 E. North  
Callaghan, Mrs. W. C.  
Lincoln Park R. R. 1  
Dickson, Mrs. Dale D.  
825 N. Broadway  
McKee, Mrs. Harry S. 190 N. Mich.  
Morrison, Mrs. J. Trevor N. Mich.  
Overpeck, Mrs. Charles... R. R. 8  
Sallee, Mrs. Wm. T., 245 S. Mich.  
Shaffer, Mrs. William R.  
R. R. 1, Lincoln Park

**DELAWARE-BLACKFORD  
COUNTIES**

Brown, Mrs. Stewart D... Albany  
Puterbaugh, Mrs. Karl... Albany  
Daleville  
Hurley, Mrs. John  
Rutledge, Mrs. Jean  
Tucker, Mrs. O. A.  
Gaston  
Downard, Mrs. Leland F.  
Montgomery, Mrs. Lall G.  
Box 149, ARFD 1  
Douglas, Mrs. William Montpelier  
**Muncie**  
A  
Adams, Mrs. William B.  
W. Jackson St. Pike

Anthony, Mrs. Harvey M.  
822 W. Charles  
**B**  
Ball, Mrs. Clay A... 1015 Linden  
Ball, Mrs. Philip... 921 W. Main  
Bibler, Mrs. Henry... Parkway Dr.  
Botkin, Mrs. Clyde G.  
2904 Riverside Ave.  
Botkir, Mrs. Tom... 1007 W. North  
Bowles, Mrs. Herman 324 N. Vine  
Bowles, Mrs. John H... 408 Wayne  
Brown Mrs. Karl T., 905 E. Adams  
Brown, Mrs. Leland... 2012 W. 9th  
Brown, Miss Nellie Gates  
Brown, Mrs. Thomas  
R. R. 6, Box 171  
Bryan, Mrs. T. L.  
1625½ University Ave.  
Burwell, Mrs. Stanley W.  
211 N. Calvert  
Butterfield, Mrs. Robert  
1002 W. Gilbert  
Butz, Mrs. Ralph 2707 W. North  
**C**  
Clauser, Mrs. Eldo... 1 Briar Rd.  
Clevenger, Mrs. Joseph H.  
3124 University Ave.  
Cole, Mrs. Russell E.  
431 W. Howard  
Covalt, Mrs. Wendell... 120 Berwyn  
Cure, Mrs. Elmer T.  
913 University Ave.  
**D**  
Davis, Mrs. Ed. C. Parkway Drive  
Deutsch, Mrs. Wm. 2100 Petty Rd.  
Dunn, Mrs. Farrell W.  
1416 Wheeling Ave.  
**E-F**  
Eissman, Mrs. Eugene,  
211 Alden Rd.  
Funk, Mrs. John  
3700 Peachtree Lane  
**G**  
Garling, Mrs. L. C... 37 Briar Rd.  
Gill, Mrs. Tom... 45 Warwick Road  
Greiber, Mrs. Marvin 310 Riley Rd.  
Gustafson, Mrs. Milton H.  
230 Stradling Rd.  
**H-I**  
Hall, Mrs. O. A. 3121 W. Gilbert  
Harris, Mrs. Edmund J.  
409 Carson  
Hayes, Mrs. T. R... 920 W. North  
Henderson, Mrs. Ramon  
75 Warwick Rd.  
High, Mrs. Ralph  
2825 University Ave.  
Hill, Mrs. Frank... 321 Calvert  
Hill, Mrs. Howard 106 Berwyn Rd.  
Hill, Mrs. Robert  
State Rd. No. 3 South  
Hostetter, Mrs. I. S. 300 Winthrop  
Hurley, Mrs. Anson  
1007 University  
Imhof, Mrs. J. D.  
307 Granville Ave.  
**K**  
Kammer, Mrs. Walter F.  
W. Parkway Drive  
Kemper, Mrs. Arthur  
600 E. Wash.  
Kirshman, Mrs. F. E. 41 Briar Rd.  
Ko, Mrs. Richard... R. R. 7  
Kuder, Mrs. Howard F.  
1208 N. Walnut

**M**  
Mason, Mrs. L. R.,  
3013 Oaklyn Ave.  
McClellan, Mrs. John 331 E Adams  
McClintock, Mrs. James A.  
611 Beechwood  
McCoy, Mrs. George 517 S. Talley  
Molloy, Mrs. W. J., 619 E. Charles  
McDowell, Mrs. Fletcher  
500 W. Main  
Moore, Mrs. Tom... 906 Marsh  
Morris, Mrs. J. W.  
222 Stradling Rd.  
Moss, Mrs. M. J.  
1010 W. Parkway Dr.  
**O**  
Owens, Mrs. O. W... 2600 Godman  
Owens, Mrs. Richard R.  
3011 Oaklyn Ave.  
Owens, Mrs. Thomas  
608 E. Charles  
**P-Q**  
Peacock, Mrs. Robert  
State Road 67  
Poland, Mrs. U. G... 303 E.  
Washington  
Quick, Mrs. Wm.  
2009 University Ave.  
**R**  
Rettig, Mrs. Arthur  
611 W. Howard  
Rivers, Mrs. Glynn  
1334 N. Walnut  
**S**  
Saperstein, Mrs. Morris  
706 New York Ave.  
Schulhof, Mrs. M. G.  
921 W. Parkway  
Silver, Mrs. Richard  
9 Parkway Dr.  
Silvers, Mrs. J. C. 319 S. Franklin  
Silvers, Mrs. J. M... 220 W. Adams  
Stanley, Mrs. John R.  
2505 W. Gilbert  
Starks, Mrs. William... 825 Haines  
Stocking, Mrs. Bruce,  
3014 Amherst  
Stout, Mrs. Francis  
1003 University  
**T**  
Tindal, Mrs. E. F. 423 W. Jackson  
Tomlin, Mrs. Hugh M.  
3115 Amherst  
**V-W**  
Venis, Mrs. Kemper... 502 Wade  
Wadsworth, Mrs. W. W.  
306 E. Jackson  
Williams, Mrs. J. H. 905 W. North  
Wright, Mrs. C. H... 715 Rex  
**Y**  
Young, Mrs. G. S. 114 Berwyn Rd.  
Hinchman, Mrs. Jean... Parker  
Moore, Mrs. Will C... Yorktown  
**DUBOIS COUNTY**  
Barrow, Mrs. John... Dale  
Backer, Mrs. Henry George  
Ohio St., Ferdinand  
**Huntingburg**  
Amini, Mrs. S... 105 Van Buren  
Bretz, Mrs. John... 222 Van Buren  
Steinkamp, Mrs. Emil... 302 Walnut  
Stork, Mrs. Harvey K... 523 1st  
Williams, Mrs. Charles... 4th Ave.

**DUBOIS COUNTY**

(Continued)

Williams, Mrs. Fielding 511 Geiger  
Williams, Mrs. Flora... 511 Geiger

**Jasper**

Casper, Mrs. Joseph  
Terrace Heights

Gootee, Mrs. Thomas  
105 Central Bldg.  
Heck, Mrs. Martin C... 388 W. 15th  
Held, Mrs. George A... 716 W. 9th  
Klammer, Mrs. Charles H.  
424 W. 6th

Ploetner, Mrs. Edward  
1424 Jackson St.  
Wagner, Mrs. Arthur... R.F.D. 5

**ELKHART COUNTY****Bristol**

Neidballa, Mrs. E. G... R.F.D. 1  
Patrick, Mrs. G. B... R.F.D. 1  
Schlosser, Mrs. H. C. Seven Gables

**Elkhart**

Bender, Mrs. R. L. 125 N. Riverside  
Billings, Mrs. Elmer  
165 Gage Ave.  
Bloom, Mrs. George R.  
130 Glendale

Bolin, Mrs. Robert S.  
1853 East Beardsley  
Bowdoin, Mrs. George E.  
3809 Greenleaf Blvd.

Compton, Mrs. Walter A.  
2225 Greenleaf Blvd.  
Conklin, Mrs. R. L. 1906 E. Jackson  
Cormican, Mrs. Herbert L.  
1621 E. Jackson

Crandall, Mrs. L. A., Jr.  
Crandall's Pond, R.F.D. 3  
DeDario, Mrs. L. M.  
1418 Greenleaf Blvd.

Dovey, Mrs. E. G... 1430 Ervin  
Elliot, Mrs. L. A.  
R. R. 1, Edwardsburg, Mich.  
Elliot, Mrs. Thomas A.  
2001 Stevens

Fleming, Mrs. Claude F.  
229 W. Jackson  
Fleming, Mrs. J. Millard  
2220 E. Jackson

Futterknecht, Mrs. James C.  
2012 Morton Ave.  
Horswell, Mrs. R. G.  
1629 E. Jackson Blvd.

Hull, Mrs. A. W... 905 Strong  
Hunn, Mrs. M. F. 202 W. Beardsley  
Ivy, Mrs. John H.  
413½ W. Franklin St.

Kintner, Mrs. Burton E.  
3520 E. Jackson  
Koehler, Mrs. Elmer G.  
R. R. 1, Edwardsburg, Mich.

Leasure, Mrs. Kenneth E.  
320 Cleveland Ave.  
Lehman, Mrs. W. J.  
2218 E. Jackson Blvd.

Logan, Mrs. Richard... 706 Fulton  
Lundt, Mrs. Milo O... 519 S. 2nd  
Markel, Mrs. I. J. 215 W. Franklin  
McArt, Mrs. Bruce A.  
654 Fulton Road

Mendez, Mrs. Carlos  
325 Superior Blvd.  
Miller, Mrs. Hugh A., Jr.  
309 E. Crawford

Mininger, Mrs. Edward P.  
409 Prospect

Mishkin, Mrs. Irving  
217 N. Riverside Dr.

Norris, Mrs. Allen A.  
401 W. Marion

Paff, Mrs. Wm. A. 2601 E. Jackson  
Paine, Mrs. George D. 329 Meisner  
Pancost, Mrs. Vernon  
160 Riverview Ave.

Rohr, Mrs. J. H... 1843 Grant  
Rouen, Mrs. Robert L.  
816 Christiana St.

Rupe, Mrs. L. O. 116 W. Dinehart  
Sears, Mrs. M. Maywood  
R.F.D. 3, West Indiana

Spray, Mrs. Page. 658 Kilbourne  
Stauffer, Mrs. W. A. 701 Strong  
Stout, Mrs. R. B. 1501 Greenleaf  
Stubbins, Mrs. William  
1203 E. Jackson Blvd.

Swihart, Mrs. Homer R.  
220 Meisner  
Swihart, Mrs. L. F.  
2120 Broadmoor Dr.

Todd, Mrs. David D.  
2001 E. Jackson  
Wilson, Mrs. O. E.  
2505 Greenleaf Blvd.

Work, Mrs. James A., Jr.  
4 St. Joseph Manor  
Yoder, Mrs. C. Richard  
130 N. Corona

**Goshen**

Bender, Mrs. C. K... 624 S. 5th  
Bigler, Mrs. Fredrick... 314 S. 5th  
Bosler, Mrs. Howard A.  
Waterford Mills, R. R. 5

Chandler, Mrs. L. H... 412 S. 5th  
Freeman, Mrs. F. M. 309 E. Wash.  
Hostetler, Mrs. C. M. 1602 S. 8th  
Martin, Mrs. Floyd S... R.F.D. 5  
Nelson, Mrs. D. Chester  
1210 S. 8th

Simmons, Mrs. Lloyd H. 606 S. 3rd  
Turner, Mrs. John... R.F.D. 2  
Vander Bogart, Mrs. Harry E.  
1411 S. 8th

Wagner, Mrs. D. G... 307 S. 7th  
Yoder, Mrs. Albert C... 816 S. 6th  
Norris, Mrs. Ernest... Middlebury

**Nappanee**

Fleetwood, Mrs. R. A.  
151 E. Van Buren  
Kendall, Mrs. F. M. 801 E. Market  
Price, Mrs. Douglas W.  
458 N. Madison

Slabaugh, Mrs. L. M. 402 N. Main  
Slabaugh, Mrs. J. S... 258 N. Main

Massanari, Mrs. Walter  
Millersburg

Fosbrink, Mrs. E. L... Syracuse  
Amick, Mrs. Charles L... Wakarusa  
Hannah, Mrs. Jack W... Wakarusa

**FAYETTE-FRANKLIN COUNTIES****Brookville**

Foreman, Mrs. Walter A. 617 Main  
Smith, Mrs. H. N... 812 Main  
Seal, Mrs. Perry F... 901 Main

**Connersville**

Ashworth, Mrs. Juanita  
2027 Indiana Ave.  
Booher, Mrs. Martha  
1609 Virginia Ave.

Brookman, Mrs. Robert E.  
2750 Grand Ave.

Ellis, Mrs. George M. 516 W. 29th  
Fettig, Mrs. Lucille  
1609 Virginia Ave.

Fruth, Mrs. Virgil J.  
1603 Virginia Ave.

Gregg, Mrs. Albert F.  
835 Lincoln Ave.

Hudson, Mrs. Arlington  
2156 Vermont Ave.

Kemp, Mrs. W. Alfred 403 W. 28th  
Kerrigan, Mrs. William F.  
212 N. 12th St.

Leffel, Mrs. Glen  
1810 Indiana Ave.

Lockhart, Mrs. Jack M.  
2918 Vermont Ave.

Metcalfe, Mrs. Alma  
1805 Virginia Ave.

Moore, Mrs. Hollis. 126½ W. 11th  
Morrow, Mrs. Roy D.  
629½ Eastern Ave.

Mountain, Mrs. Francis B.  
1720 Virginia Ave.

Poston, Mrs. C. L... R. R. 2  
Sanders, Mrs. Bertram  
1603 Virginia Ave.

Smelser, Mrs. Herman W.  
2530 Grand Ave.

Steinam, Mrs. Joseph L.  
2300 Grand Ave.

Watterson, Mrs. Gerald T.  
1910 Virginia Ave.

**FLOYD COUNTY**

Engleman, Mrs. H. K. Georgetown  
Jeffersonville

Baxter, Mrs. S. M... Centralia  
Gentile, Mrs. John P.  
3405 Centralia Ct.

McCullough, Mrs. J. Y... Centralia  
New Albany

Allen, Mrs. Fred K. 2015 Lindberg  
Baker, Mrs. A. M. 2523 Glenwood  
Baxter, Mrs. J. W., Jr.  
426 Woodrow Ave.

Bird, Mrs. J. E... 1308 E. Spring  
Briscoe, Mrs. C. E. 1413 E. Spring  
Brown, Mrs. K. H.  
1654 Hedden Park

Byrn, Mrs. Howard  
330 Beharrel Ave.

Davis, Mrs. Parvin... Paoli Pike  
Day, Mrs. George... Hausfelt Lane  
Edwards, Mrs. W. F.  
615 Beharrel Ave.

Garner, Mrs. Wm. H.  
922 E. Spring

Hauss, Mrs. A. P... Silver Hills  
Hess, Mrs. P. Patrick  
1721 Lilly Lane

Higgins, Mrs. John  
Old Vincennes Rd.

LaFollette, Mrs. Donald R.  
Crestview

LaFollette, Mrs. Robert E.  
2510 Glenwood Park

Leuthart, Mrs. C. P.  
1410 E. Spring

Pace, Mrs. Jerome  
Silvercrest, Old Vincennes Rd.

Paris, Mrs. John M.  
2003 Lindberg Ct.

Pierson, Mrs. Percy R. 1430 Silver

Pierce, Mrs. Gene S.  
1707 Lynnwood Drive

Robertson, Mrs. A. N... 323 E. 9th

Rogers, Mrs. S. T... 1017 E. Spring



## (New Albany—Continued)

Streepey, Mrs. Jefferson  
1919 Depauw Ave.  
Tyler, Mrs. F. T. . . . . Daisy Lane  
Voylez, Mrs. Harry  
425 Beharrel Ave.  
Weaver, Mrs. W. W.  
1752 Lynwood Drive  
Winstandley, Mrs. Wm.  
815 Vincennes  
Wohlfeld, Mrs. Gerald  
Silvercrest, Old Vincennes Rd.  
Wolfe, Mrs. Nelson A.  
1117 E. Spring

**FULTON COUNTY**

Miller, Mrs. Virgil C. . . . . Akron  
Stinson, Mrs. Arthur E. . . . Athens  
Glackman, Mrs. John C. . . . Culver  
Kraning, Mrs. Kenneth K.  
Kewanna  
Kelsey, Mrs. Lawrence E.  
Kewanna  
Rochester  
Dielman, Mrs. Franklin C.  
920 Jefferson  
Herendeen, Mrs. Elbie V.  
317 W. 7th  
King, Mrs. Milo O. 110½ E. 8th  
Knotts, Mrs. Slater. . . . 328 Clay  
Richardson, Mrs. Chas. L.  
506 Pontiac  
Rowe, Mrs. Howard H. 417 W. 9th  
Stinson, Mrs. Dean K. 1318 Main

**GIBSON COUNTY**

Geick, Mrs. R. G.  
207 N. Main, Ft. Branch  
Hollis, Mrs. W. H.  
607 E. Locust, Ft. Branch  
Marchand, Mrs. Edwin V.  
Haubstadt  
Turner, Mrs. M. A.  
322 W. Columbia, Oakland City  
Wood, Mrs. Russell W.  
628 W. Oak St.

**Princeton**

Alexander, Mrs. H. H.  
427 W. State  
Carpentier, Mrs. H. F. 319 E. State  
Folck, Mrs. J. K. . . . . 530 N. Hart  
Graves, Mrs. O. M. 116 E. Spruce  
McCarthy, Mrs. Virgil  
403 W. Spruce  
McElroy, Mrs. R. S. 404 W. Walnut  
Peck, Mrs. J. F. Outer W. Monroe  
Weitzel, Mrs. R. E. 309 W. Spruce

**GRANT COUNTY**

Malott, Mrs. Fred. . . . . Converse  
Grant, Mrs. Arthur. . . . Fairmount  
Garrison, Mrs. L. J.  
305 E. S. "C" St., Gas City  
Koontz, Mrs. William A.  
315 E. S. "A" St., Gas City

**Marion**

Abel, Mrs. Charles Wabash Ave.  
Alderfer, Mrs. Henry 806 W. 1st  
Ansbacher, Mrs. Stefan. . . . R. R. 1  
Ayres, Mrs. W. W.  
820 Jeffras Ave.  
Bloom, Mrs. A. Ward  
1111 Euclid Ave.  
Comeau, Mrs. Wm. . . . . R. R. 6  
Currie, Mrs. Robert. . . . . R. R. 3  
Daniels, Mrs. E. O. 106 N. "E" St.

Daniels, Mrs. George R.  
822 W. Fourth  
Davis, Mrs. Merrill S.  
723 Euclid Ave.  
Davis, Mrs. Richard 1321 W. 4th  
Diamond, Mrs. Leo L.  
617 Spencer Ave.  
Eshleman, Mrs. L. H.  
2923 S. Washington  
Fisher, Mrs. Henry  
1502 S. Washington  
Ganz, Mrs. Max. . . . . 904 Jeffras  
Hummel, Mrs. R. M. Shady Hills  
Jarrett, Mrs. John  
514 Wabash Ave.  
Lavengood, Mrs. Russell W.  
State Rd. 15 N.  
Love, Mrs. V. Logan  
Hickory Hills  
McIlwain, Dr. Eleanor  
2107 S. Boots  
Powell, Mrs. J. P. 127 River Dr.  
Renbarger, Mrs. Lester  
Wabash Pike  
Rhorer, Mrs. John G. Wabash Ave.  
Simmons, Mrs. F. H.  
520 Whites Ave.  
Skomp, Mrs. C. E.  
1123 Euclid Ave.  
Sthair, Mrs. Phillip  
700 W. Third St.  
Warren, Mrs. C. B. 803 W. 6th  
Wicker, Mrs. Eugene 1119 W. 4th  
Woodbury, Mrs. J. W.  
712 S. "G" St.  
Young, Mrs. Robert, 1911 S. Boots

King, Mrs. P. C. . . . . Swayzee  
Taylor, Mrs. E. C. . . . . Upland  
Rifner, Mrs. E. S. . . . . Van Buren

**GREENE COUNTY****Bloomfield**

Graf, Mrs. Jerome  
Mount, Mrs. M. S. 340 W. Mechanic  
Turner, Mrs. H. B.  
32 N. Franklin St.  
Turner, Mrs. J. J. 227 W. Main St.

**Jasonville**

Porter, Mrs. Carl  
425 S. Meridian St.  
Rotman, Mrs. Harry  
508 S. Washington St.  
Rotman, Mrs. Sam  
608 S. Washington St.

**Linton**

Broshears, Mrs. Kenneth  
990 E. Vincennes St.

Craft, Mrs. William  
940 E. Vincennes St.  
Fleetwood, Mrs. L. B.  
489 E. Vincennes St.

Hamilton, Mrs. C. C.  
Raney, Mrs. Ben  
370 E. Vincennes St.

Woner, Mrs. John

**Worthington**

Moses, Mrs. Robert  
Moses, Mrs. George 15 N. Edwards

**HAMILTON COUNTY**

Donahue, Mrs. C. M. . . . . Carmel  
Havens, Mrs. Oscar . . . . . Cicero  
Noblesville  
Ambrose, Mrs. J. C. 298 N. Ninth  
Campbell, Mrs. Sam 88 S. 19th St.

Harris, Mrs. Robert 297 S. 10th St.  
Hash, Mrs. J. S. . . . . R. R. 4  
Henry, Mrs. R. S. . . . . R. R. 5  
Kraft, Mrs. H. C. . . . . R. R. 5  
Shanks, Mrs. Ray. . . . . R. R. 5  
Shonk, Mrs. H. W. North Ninth St.  
Southard, Mrs. Carl

1594 Maple Ave.  
Connoy, Mrs. Andrew. . . . Westfield  
Connoy, Mrs. Leo. . . . . Westfield

**HANCOCK COUNTY****Charlottesville**

Johnston, Mrs. W. R.  
Scott, Mrs. Robert

**Fortville**

Manifold, Mrs. Harold  
Naven, Mrs. W. K.

**Greenfield**

Allen, Mrs. Joseph. . . 17 E. South  
Endicott, Mrs. Wayne. . . N. East  
Gibbs, Mrs. Charles. 203 E. North  
Gill, Mrs. D. D. . . . . 328 Park  
Henn, Mrs. R. A. . . . Michigan Road  
Hunter, Mrs. Donn

17 Downing Court  
Kinneman, Mrs. R. E.  
236 W. North

Rariden, Mrs. L. B.  
North State St.  
Vingis, Mrs. Bronie. 705 N. State  
Woods, Mrs. James R., Jr.  
715 N. East

Larrabee, Mrs. William  
New Palestine

Pierson, Mrs. Thomas  
New Palestine  
Kuhn, Mrs. Robert. . . . Wilkinson  
Treese, Mrs. Nelle. . . . Wilkinson

**HARRISON-CRAWFORD COUNTIES****Corydon**

Amy, Mrs. William  
Blessinger, Mrs. Louis  
Brockman, Mrs. Wilfred  
Dillman, Mrs. Carl  
Benz, Mrs. Jesse. . . . . Marengo  
Davis, Mrs. Claude. . . . . Milltown

**HENDRICKS COUNTY**

Foltz, Mrs. Lloyd. . . . Brownsburg  
Scudder, Mrs. A. N. . . . Brownsburg

**Danville**

Elliot, Mrs. Paul  
348 S. Washington  
Gibbs, Mrs. Joseph W. 445 E. Mill  
Koch, Mrs. Elmer. . . . 301 S. Bowen  
Terry, Mrs. Lloyd  
402 E. Broadway

Ellis, Mrs. L. Hall. . . . . Lizton  
Scamahorn, Mrs. Malcolm

Pittsboro  
Scamahorn, Mrs. Oscar T.  
Pittsboro

**Plainfield**

Aiken, Mrs. Milo. . . . . Plainfield  
Cohen, Mrs. Irvin B.  
201 N. Hanley  
Johnson, Mrs. Alan. . . . 450 Avon  
Stafford, Mrs. J. C. . . . 223 Avon  
Stafford, Mrs. William C.  
625 S. East



**HENRY COUNTY**

Zimmerman, Mrs. W. H. . . . Dublin  
 Newnum, Mrs. R. L. . . . Hagerstown  
 Wiatt, Mrs. Leonard . . . Knightstown  
 Stauffer, Mrs. George . . . Moreland  
 Scheets, Mrs. Marion R. . . .

Lewisville

Marshall, Mrs. L. C. . . . Mt. Summit

New Castle

Amos, Mrs. Robt. L. . . .

924 Lincoln Ave.

Bitler, Mrs. C. C. . . . 603 S. 11th

Bledsoe, Mrs. J. G. . . . 319 S. 14th

Burnett, Mrs. A. B. . . . 1201 S. Main

Craig, Mrs. Alex F. . . . Route 2

Davies, Mrs. Robert R. . . .

1914 Plum St.

Fisher, Mrs. John . . . 438 S. 11th

Foster, Mrs. Ray . . . 420 N. Main

Harrison, Mrs. B. L. . . .

223 Bundy Ave.

Heilman, Mrs. William C. . . .

1111 Audubon Rd.

Hill, Mrs. Kenneth G. . . . 100 Leland

Itermann, Mrs. G. E. . . . 925 Mourer

Kennedy, Mrs. W. U. . . . 701 S. 14th

Life, Mrs. Homer L. . . . 1015 W. Broad

McDonald, Mrs. Frank C. . . .

521 S. Main

McElroy, Mrs. James S. . . .

1213 Audubon Rd.

Saint, Mrs. Wm. K. . . . Crescent Dr.

Smith, Mrs. Robt. A. . . . 1229 Lincoln

Stout, Mrs. Walter M. . . .

1103 Audubon Rd.

Thorne, Mrs. Charles E. . . .

1119 S. Main

Vivian, Mrs. Donald E. . . .

Crescent Dr.

Wiggins, Mrs. D. S. . . . 219 S. 12th

Kuhn, Mrs. Robert W. . . . Wilkinson

Robertson, Mrs. Wm. . . . Spiceland

**HOWARD COUNTY**

Denton, Mrs. Larkin . . . Greentown

Shoup, Mrs. H. P. . . . Greentown

Kokomo

Adams, Mrs. C. J. . . .

1216 W. Superior

Alward, Mrs. J. H. . . . 401 W. Walnut

Ault, Mrs. C. H. . . . Terrace Gardens

Boughman, Mrs. J. D. . . .

1515 W. Jefferson

Bowers, Mrs. C. C. . . . 1530 W. Taylor

Bowers, Mrs. Harvey B. . . .

421 Morningside

Bowers, Mrs. J. A. . . .

1535 W. Jefferson

Bruegge, Mrs. T. J. . . . 1414 Kingston

Clarke, Mrs. Elton . . .

1400 W. Sycamore

Conley, Mrs. T. M. . . .

1016 W. Superior

Craig, Mrs. R. A. . . .

W. Sycamore Road

Craig, Mrs. Ruben . . .

W. Jefferson Rd.

Crawford, Mrs. T. R. . . .

908 W. Superior

Cuthbert, Mrs. F. S. . . .

1027 W. Walnut

Earl, Mrs. M. M. . . .

1735 W. Mulberry

Ferry, Mrs. P. J. . . .

1027 W. Sycamore

Golper, Mrs. M. N. . . .

1021 W. Mulberry

Good, Mrs. R. P. . . . 227 N. Forest Dr.

Halfast, Mrs. Richard . . .

2315 S. Webster

Hutto, Miss Arvilla . . .

1012 W. Walnut

Hutto, Mrs. O. D. . . . 1012 W. Walnut

Hutto, Mrs. W. H. . . . 211 Conradt

Jewell, Mrs. G. M. . . .

1318 W. Sycamore

Kratzer, Mrs. E. F. . . . 320 E. Walnut

Lung, Mrs. Bruce . . . 115 Conradt

McClure, Mrs. Warren . . .

712 S. Union

McIndoo, Mrs. R. E. . . .

820 W. Walnut

Meiner, Mrs. J. A. . . . 924 W. Wash.

Mendelson, Mrs. Stanley . . .

323 Elliot Court

Morrison, Mrs. W. R. . . . 413 Conradt

Murray, Mrs. E. C. . . .

2200 S. Webster

Paris, Mrs. D. W. . . .

2417 S. LaFountain

Phares, Mrs. R. W. . . .

400 S. Western

Prather, Mrs. P. E. . . . 920 Lindsay

Rhorer, Mrs. H. M. . . .

511 W. Sycamore

Rudicel, Mrs. M. W. . . .

1604 Kingston Rd.

Schwartz, Mrs. F. C. . . .

1503 Kingston

Shenk, Mrs. E. M. . . . 306 N. Webster

Sorenson, Mrs. Raymond . . .

1616 W. Walnut

Spangler, Mrs. J. S. . . .

2126 S. Webster

Wilson, Mrs. William . . .

803 W. Sycamore

Evans, Mrs. Robert . . . Russiaville

**HUNTINGTON COUNTY**

Huntington

Brubaker, Mrs. Harold S. . . .

Flaxmill Rd.

Casey, Mrs. Stanley M. . . .

408 E. Market

Cope, Mrs. Stanton . . .

1022 N. Jefferson

Erehart, Mrs. Mark G. . . .

232 W. Market

Eviston, Mrs. J. Boyd . . . 1392 Poplar

Gray, Mrs. Paul M. . . . 340 E. Market

Grayston, Mrs. Fred W. . . .

708 N. Jefferson

Grayston, Mrs. Wallace S. . . .

303 E. Market

James, Mrs. Thomas, Jr. . . .

1044 Poplar

Johnston, Mrs. Robert G. . . .

339 E. Market

Marks, Mrs. Howard H. . . .

1433 Cherry

Mitman, Mrs. Floyd B. . . .

1470 Poplar

Nie, Mrs. Grover M. . . . 1518 Cherry

Omstead, Mrs. Trevalyn W. . . .

244 E. Washington

Wagner, Mrs. Richard . . .

1355 Guilford

Ware, Mrs. J. Roger . . . 622 Henry

Woods, Mrs. Halden C. . . . Markle

Galbreath, Mrs. Russell S. . . .

Rt. 2, South Whitley

Warren

Bennett, Mrs. J. B. . . .

Black, Mrs. Claude S. . . .

Smith, Mrs. Lucian W. . . .

**JENNINGS-JACKSON COUNTIES**

Gillespie, Mrs. G. R. . . . Brownstown

Shields, Mrs. Jack . . . Brownstown

Adair, Mrs. W. K. . . .

208 S. Armstrong, Crothersville

Bard, Mrs. F. B. . . .

305 E. Howard, Crothersville

Scharbrough, Mrs. Wm. . . . Medora

Calli, Mrs. Louis J. . . .

408 S. State, N. Vernon

Green, Mrs. John . . .

S. Elm, N. Vernon

Johnson, Mrs. William J. . . .

Jackson St., N. Vernon

Thayer, Mrs. Benet . . .

Jennings St., N. Vernon

Seymour

Baxter, Mrs. Harry . . . 4th & Jackson

Black, Mrs. J. M. . . . 315 N. Pine

Day, Mrs. Durbin . . . 515 W. 6th

Gillespie, Mrs. Charles E. . . .

602 N. Walnut

Graessle, Mrs. H. P. . . . 419 N. Walnut

Kamman, Miss Martha . . . 332 W. Oak

Martin, Mrs. Guy . . . 1408 Ewing Rd.

Osterman, Mrs. L. H. . . .

901 Garden Ave.

Ripley, Mrs. John W. . . . 321 Bruce

Wiethoff, Mrs. C. A. . . .

327 Calvin Blvd.

**JASPER-NEWTON COUNTIES**

Pippenger, Mrs. Wayne G. . . . Brook

Coursey, Mrs. James . . . Goodland

Mathews, Mrs. W. C. . . . Kentland

Yegerlehner, Mrs. R. S. . . . Kentland

Williams, Mrs. Hugh . . . Morocco

Hartsough, Mrs. Ralph . . . Remington

Schantz, Mrs. Richard . . . Remington

Rensselaer

Beaver, Mrs. E. R. . . .

Kresler, Mrs. L. E. . . .

Ockermann, Mrs. Kenneth . . .

Titus, Mrs. Jack . . .

**JAY COUNTY**

Heller, Mrs. Nelson L. . . . Dunkirk

Lansford, Mrs. John . . . Redkey

Portland

Badders, Mrs. Ara C. . . . 709 W. North

Cripe, Mrs. Wm. H. . . . 507 W. High

Fitzpatrick, Mrs. James S. . . .

420 N. Pleasant

Hammond, Mrs. Stanley M. . . .

S. Meridian Street Rd.

Morrison, Mrs. George G. . . .

North & Park Sts.

Spahr, Mrs. Donald E. . . . 615 W. Race

Steffy, Mrs. Ralph . . . 321 E. Race

**JEFFERSON COUNTY**

Madison

Alcorn, Mrs. Merritt O. . . . R. R. 1

Beetem, Mrs. Luther F. . . .

411 N. Broadway

Childs, Mrs. Wallace . . . Edward

Elm & Third

Hare, Mrs. Frank W. . . .

525 W. Third

**JEFFERSON COUNTY**

(Madison—Continued)

Jolly, Mrs. Lewis Everette  
J. P. G. Area  
May, Mrs. George Arthur... R.R. 5  
McAtee, Mrs. Ott B.  
Madison State Hospital  
Murry, Mrs. Wm. E.  
Madison State Hospital  
Petway, Mrs. Allen Paul  
411 W. 1st  
Rains, Mrs. Rinda  
117 Presbyterian Ave.  
Shuck, Mrs. Wm. A. .... R.R. 3  
Whitsitt, Mrs. Schuyler  
718 W. Main  
Zink, Mrs. Robert Otto... 426 Vine

**JOHNSON COUNTY**

Franklin

Chappel, Mrs. A. T. ... 551 Center St.  
Deppe, Mrs. Charles F.  
1215 Park Ave.  
Ferrara, Mrs. Joseph ... 1000 E. King  
Poster, Mrs. R. H. K.  
Orchard Grove  
Jones, Mrs. Charles A. ... E. Adams  
Manuel, Mrs. Donald C.  
89 N. Walnut  
Murphy, Mrs. Harry E.  
150 N. Main  
Payne, Mrs. Carl F. ... 151 N. Main  
Portteus, Mrs. Walter L.  
R. R. 2, Box 118  
Province, Mrs. Wm. D. .... R.R. 3  
Records, Mrs. Arthur W.  
216 E. Jefferson  
Stogsdill, Mrs. W. W.  
Cor. Walnut & Madison Sts.  
Wilson, Mrs. Russell. ... 351 E. King  
Greenwood  
Brown, Mrs. George E.  
Beech Park Dr.  
Craig, Mrs. J. A. .... E. Pearl  
Eaton, Mrs. Lyman D.  
Springdale Addition  
Machledt, Mrs. John H.  
243 S. Madison  
Sheek, Mrs. Kenneth I.  
165 N. Brewer  
Woodcock, Mrs. Charles W.  
240 S. Madison

**KNOX COUNTY**

Scudder, Mrs. J. A. ... Edwardsport  
Vincennes  
Anderson, Mrs. John  
Old Wheatland Road  
Anderson, Mrs. Richard M.  
Monroe City Rd.  
Arbogast, Mrs. Paul B.  
1420 Old Orchard Rd.  
Beckes, Mrs. Elsworth W.  
220 N. 5th  
Chattin, Mrs. Herbert O.  
729 Main  
Coffel, Mrs. Melvin H.  
Simpson Lake  
Cullison, Mrs. Charles H.  
47 Cloverdale  
Curtner, Mrs. Myron L. ... 216 N. 6th  
Edwards, Mrs. Edward T., Jr.  
1232 N. 11th  
Ewing, Mrs. Nathaniel D.  
Monroe City Rd.  
Fox, Mrs. Maurice S. ... 704 N. 7th  
Green, Mrs. Carl L.  
1414 Weed Lane

Humphreys, Mrs. Joe S.  
1602 Weed Lane  
Keezer, Mrs. Wm. .... 515 Perry  
McCormick, Mrs. Hubert D.  
518 N. 4th  
McDowell, Mrs. M. M.  
1322 Audubon Rd.  
McMahan, Mrs. V. C.  
Monroe City Road  
Moore, Mrs. Robert G.  
1309 Old Orchard Rd.  
Reilly, Mrs. James F.  
403 Buntin  
Schulze, Mrs. Wm. .... 819 Buntin  
Shaffer, Mrs. Kenneth ... Ridge Rd.  
Small, Mrs. E. F. .... 526 Scott  
Smith, Mrs. Ralph O.  
Old Burceville Rd.  
Spencer, Mrs. Frederic ... 311 N. 9th  
Sullenger, Mrs. A. A.  
8th & Seminary  
Von der Lief, Mrs. William  
7th & Main  
Welch, Mrs. Norbert M.  
Monroe City Rd.

**KOSCIUSKO COUNTY**

Urschel, Mrs. Dan L. .... Mentone  
Stalter, Mrs. G. W.  
North Webster  
Warsaw  
Haymond, Mrs. G. M.  
532 E. Center  
Murphy, Mrs. Harold  
427 S. Buffalo  
Murphy, Mrs. Samuel C.  
216 S. High  
Richer, Mrs. Orville H.  
914 E. Main  
Roesch, Mrs. Ryland ... N. Lake  
Schlemmer, Mrs. George H.  
528 N. Lake  
Thomas, Mrs. E. Winton ... E. Main

**LAKE COUNTY**

Stasick, Mrs. Murray  
307-154th Place, Calumet City, Ill.  
Crown Point  
Becker, Mrs. P. H.  
Parramore Hospital  
Birdzell, Mrs. J. P.  
Ellendale Pkwy.  
Horst, Mrs. W. N. .... 126 N. Court  
Klaus, Mrs. J. N. .... 667 S. Main  
Troutwine, Mrs. W. R. .... S. Main  
Carleton, Mrs. E. H.  
R.R. 1, Box 175, Dyer  
East Chicago  
Arnold, Mrs. M. F. ... 4239 Magoun  
Bonaventura, Mrs. Angelo P.  
1604 E. 142nd  
Ernst, Mrs. H. C. .... 4219 Baring  
Fleischer, Mrs. J. C. .... 4135 Ivy  
Grosso, Mrs. William G.  
3502 Grand Blvd.  
Gustaitis, Mrs. John W.  
4318 Parrish  
McGuire, Mrs. Desmond F.  
1910 142nd  
Niblick, Mrs. James S.  
4122 Parrish  
Petronella, Mrs. Sam J.  
4308 Baring  
Shapiro, Mrs. Joseph ... 4216 Ivy  
East Gary  
Mather, Mrs. Wilford ... 2367 Vigo

**Gary**

Almquist, Mrs. R. E. ... 669 Buchanan  
Almquist, Mrs. C. O. ... 550 Lincoln  
Armalavage, Mrs. L. J.  
553 Taney  
Auten, Mrs. D. S. .... 553 Lincoln  
Behn, Mrs. Walter ... 652 McKinley  
Bendler, Mrs. Carl H.  
225 Morningside  
Bills, Mrs. R. N. .... 534 Lincoln  
Brady, Mrs. Samuel J. ... 451 Garfield  
Brandman, Mrs. Harry ... 629 Grant  
Brinko, Mrs. John ... 1113 Clay  
Carberry, Mrs. G.  
2212 W. 5th Avenue  
Carbone, Mrs. Joseph  
526 Johnson  
Chevigny, Mrs. J. J. ... 654 Johnson  
Cooper, Mrs. Leo K. .... 670 Hayes  
Davis, Mrs. Neal  
Box 928, Ogden Dunes  
Dierolf, Mrs. Edward J.  
630 Montgomery  
Elliott, Mrs. Ralph A. ... 1726 W. 6th  
English, Mrs. Hubert M. ... 575 Taft  
Goldberg, Mrs. Harold B.  
3643 Tyler  
Goldstone, Mrs. Adolph  
1430 W. 7th St.  
Goldstone, Mrs. Joseph  
600 Cleveland  
Goldstone, Mrs. Sidney R.  
566 Taft  
Jahns, Mrs. A. A. ... 655 Roosevelt  
Jannasch, Mrs. M. Clifford  
2140 W. 2nd  
Kendrick, Mrs. Frank J.  
552 Johnson  
Kobrin, Mrs. Meyer W.  
2300 W. 6th  
Kopcha, Mrs. Joseph E. ... 715 Hayes  
Korn, Mrs. Jerome M.  
2119 W. 5th  
Lebioda, Mrs. Henry S.  
230 Morningside  
Lewis, Mrs. George N.  
463 Taft Place  
May, Mrs. R. Milton  
667 Van Buren  
Minczewski, Mrs. R. C. ... 361 Chase  
Molengraft, Mrs. C. J.  
544 Monroe  
Morris, Mrs. Hyman R.  
558 Taney Place  
Moswin, Mrs. Jack A. ... 477 Arthur  
Ornelas, Mrs. Joseph P.  
230 W. 36th  
Palmer, Mrs. Russell H.  
2006 W. 4th Place  
Robinson, Mrs. Walter K.  
500 N. Montgomery  
Rubin, Mrs. Simon S. ... 2131 W. 5th  
Ryan, Mrs. H. J. .... 630 McKinley  
Sala, Mrs. Joseph J. ... 2333 W. 5th  
Sala, Mrs. Walter R. ... 2035 W. 8th  
Senese, Mrs. Thomas J.  
581 Johnson  
Shevick, Mrs. Alexander  
749 Fillmore  
Slama, Mrs. George F.  
3624 Buchanan  
Spellman, Mrs. F. W. ... 640 Illinois  
Stimson, Mrs. Harry R.  
4338 Jefferson  
Thomas, Mrs. Daniel D.  
831 Garfield  
Thomas, Mrs. G. L. ... 594 Taney



## LAKE COUNTY

## (Gary—Continued)

Verplank, Mrs. G. L.  
R. R. 1, 57th & Cleveland  
Vye, Mrs. J. Preston  
3620 Madison  
Weiskopf, Mrs. Henry S.  
608 Roosevelt  
Yocum, Mrs. Paul S. 6999 Hemlock  
Young, Mrs. G. M. 4580 Wash.  
Young, Mrs. Robert L.  
616 Roosevelt  
Watts, Mrs. A. A. 620 Lincoln  
Wicks, Mrs. C. O. 560 Van Buren

## Griffith

Lundeberg, Mrs. Ralph A.  
303 N. Harvey  
Malmstone, Mrs. Francis A.  
114 E. Main  
Siekierski, Mrs. Joseph M.  
445 Broadway

## Hammond

Allegretti, Mrs. Michael L.  
6237 Forest  
Beconovich, Mrs. Robert 839 169th  
Beilke, Mrs. C. A. 6806 Huron  
Black, Mrs. Charles  
6447 Alexander  
Brown, Mrs. Stanley Lee  
6550 Hohman  
Chidlaw, Mrs. B. W.  
29 Wildwood Rd.  
Clancy, Mrs. James F. 7258 Forest  
Cook, Mrs. George M. 6607 Forest  
Cotter, Mrs. Edward R.  
7225 Knickerbocker  
Eggers, Mrs. Henry W.  
6542 Hohman  
Egnatz, Jr., Mrs. Nicholas  
840 Highland  
Elledge, Mrs. Ray 6415 Forest  
Fischer, Mrs. Burnell  
7403 Van Buren  
Gardner, Mrs. H. Glenn  
47 Waltham  
Gevirtz, Mrs. Milton B.  
6528 Forest  
Hansen, Mrs. Arthur H.  
28 Wildwood Road  
Hickman, Mrs. A. Lee, Jr.  
614 165th  
Hopkins, Mrs. J. R. 265 Conkey  
Howard, Mrs. William H.  
6534 Forest Ave.  
Husted, Mrs. Robert G.  
7248 Forest  
Komoroske, Mrs. John E.  
35 Highland  
Koransky, Mrs. David S.  
7048 Forest  
Lazo, Mrs. Vincente R. 734 Sibley  
Marks, Mrs. Ora L. 7111 Olcott  
Modjeski, Mrs. Raymond J.  
223 Locust  
Nakadate, Mrs. K. J.  
907 173rd Place  
Neal, Mrs. L. W. 7507 Olcott  
Nelson, Mrs. Richard B. 41 172nd  
Nichols, Mrs. Henrietta 15 Warren  
Panares, Mrs. S. V. 4 172nd Place  
Peck, Mrs. Edward A.  
6422 Moraine  
Pilot, Mrs. Jean  
7137 Knickerbocker Pkwy.  
Premuda, Mrs. Franklin F.  
6545 Alexander

Remich, Mrs. Antone C.

6412 Moraine  
Rendel, Mrs. Donald T. 18 172nd  
Rhind, Mrs. A. W. 7126 Forest  
Row, Mrs. P. Q. 6706 Hohman  
Rudolph, Mrs. F. G. 216 Lawndale  
Santare, Mrs. Vincent  
7321 Delaware  
Schlesinger, Mrs. J. 7251 Forest  
Shanklin, Mrs. E. M. 14 Ruth  
Stern, Mrs. S. Lewis 226 Oakwood  
Stevens, Mrs. E. W. 6913 Monroe  
Teegarden, Jr., Mrs. J. A.  
7204 Woodmar  
Thegze, Mrs. George 7435 Olcott  
Walker, Mrs. A. P. 1135 River  
Wood, Mrs. Frederic H.  
5960 Hyslop

Markey, Mrs. Richard J.

8740 Cottage Grove, Highland  
Riordan, Mrs. J. F.  
2145 Lincoln, Highland  
Dupes, Mrs. L. E.  
727 Main, Hobart  
Markle, Mrs. Joseph  
308 Main, Hobart  
Murphy, Mrs. J. F. 17634 Maple  
Potts, Mrs. William,  
3543 Ridge Rd., E., Lansing, Ill.  
Mirro, Mrs. John A. Lowell  
Munster  
Arbeiter, Mrs. Herbert I.  
229 Belden Place  
Arrowsmith, Mrs. James L.  
8138 Forest  
Benchik, Mrs. Frank A.  
8326 Hawthorn  
Boys, Mrs. F. F. 8517 Crestwood  
Campbell, Mrs. G. G.  
211 Ridge Rd.

Eggers, Mrs. Ernest L.

8147 Meadow Lane  
Friedman, Mrs. I. E.  
11 Beverly Place  
Kenny, Mrs. Francis  
8131 Forest Ave.  
Larrabee, Mrs. J. 8143 State Line  
Lautz, Mrs. Herbert A.  
7943 Forest Ave.  
Marks, Mrs. Salvo P.  
8320 Parkview  
Rosevear, Mrs. Henry J.  
230 Belden  
Teplinsky, Mrs. L. L.  
222 Beacon Pl.

## Whiting

Dainko, Mrs. Alfred D. 618 118th  
Jones, Mrs. C. M. 1925 Westpark  
Stecy, Mrs. Peter 1543 Warwick  
Weinberg, Mrs. B. A.  
2022 Lake Ave.

## LAPORTE COUNTY

Oak, Mrs. D. D., Jr. Hanna  
Oak, Mrs. D. D., Sr. LaCrosse

## LaPorte

Carter, Mrs. Fred 402 E. Jefferson  
Farnsworth, Mrs. S. A. 117 Fox  
Jones, Mrs. R. B. 1515 Indiana  
Kelsey, Mrs. Robert 2107 Monroe  
Kepler, Mrs. Robert W. 1529 Mich.  
Larson, Mrs. G. O. 1006 Monroe  
Mead, Mrs. Frank  
336 Grayson Road  
Muhleman, Mrs. C. E. Greenacres  
Richter, Mrs. J. C. 1421 Indiana  
Wolf, Mrs. John 1412 Indiana

## Michigan City

Armstrong, Mrs. T. D.  
E. Coolspring  
Bankoff, Mrs. M. L. 1412 Wash.  
Bernoske, Mrs. Daniel 731 Pine  
Carlson, Mrs. N. R. Edgewood  
Cleveland, Mrs. John B. 314 Fir  
Fargher, Mrs. F. M.  
Pottawattomie Park  
Feerer, Mrs. Donald J. 120 Wilshire  
Frost, Mrs. R. J. 817 Pine  
Gardner, Mrs. R. A. Long Beach  
Gilmore, Mrs. Russell  
Duneland Beach  
Gilmore, Mrs. Robert  
2234 Oriole Trail  
Jones, Mrs. King  
East Coolspring Ave.  
Kerrigan, Mrs. J. V.  
E. Coolspring  
Kling, Mrs. Victor Long Beach  
Krieger, Mrs. G. M.  
701 Washington  
Kubik, Mrs. F. J.  
Pottawattomie Park  
Meyer, Mrs. Milo Long Beach  
Molenda, Mrs. R. V.  
807 Greenwood Avenue  
Piazza, Mrs. L. F. 2402 York  
Pilecki, Mrs. Peter J. 410 Emily  
Plank, Mrs. C. R. Long Beach  
Potter, Mrs. Brian 1617 Springland  
Reed, Dr. Nelle C. 3210 Tilden  
Shortall, Mrs. James P.  
2948 Mt. Claireway, Long Beach  
Stumer, Mrs. M. 440 Beverly Ct.  
Feerer, Mrs. Donald 117 W. 7th  
Kohrman, Mrs. B. M. 3011 Franklin  
Kemp, Mrs. John 631 Pine

Benz, Mrs. O. F. Wanatah  
Hetman, Mrs. M. J. Westville  
Hoover, Mrs. A. W.

2005 Oriole Trail, Long Beach,  
Westville  
VanDen Bosch, Mrs. W.  
c/o Beatty Mem. Hosp., Westville

## LAWRENCE COUNTY

## Bedford

Allen, Mrs. L. Howard  
1318 Fourteenth  
Austin, Mrs. Richard P.  
1315 Fifteenth  
Benham, Mrs. Lawrence E.  
Eastern Ave.  
Dusard, Mrs. Joseph C. 1107 N.  
Edmonds, Mrs. Kendrick T.  
1303 Fifteenth  
Emery, Mrs. Charles B.  
Brook Knoll  
Fountaine, Mrs. Thomas J.  
1620 Eighteenth  
Hammel, Mrs. Howard T.  
1822 Fifteenth  
Kerr, Mrs. Donald M. 2323 Q  
Newland, Mrs. A. E.  
Hawthorne Pl.  
Noe, Mrs. William R.  
1224 Fourteenth  
Scherschel, Mrs. John P. 1713 H  
Smallwood, Mrs. R. B.  
1506 Thirteenth  
Wohlfeld, Mrs. J. B.  
1224 Fifteenth  
Hamilton, Mrs. James Mitchell



**MADISON COUNTY****Anderson**

Aagesen, Mrs. W. J. Forest Hills  
 Armington, Mrs. John C.  
     206 West 14th Street  
 Armington, Mrs. R. L. Kilbuck Rd.  
 Ashcraft, Mrs. J. R. 1225 E. 11th  
 Ayres, Mrs. Kenneth D.  
     2210 Meridian  
 Austin, Mrs. Maynard A.  
     238 W. 12th  
 Benoit, Mrs. Merrill  
     3620 Maple Road, Edgewood  
 Bixler, Mrs. Donald P.  
     1008 E. 38th  
 Blassaras, Mrs. Crist A.  
     Forest Hills  
 Brock, Mrs. Earl E.  
     Madison Heights  
 Brown, Mrs. James M. 727 E. 31st  
 Buckles, Mrs. David L.  
     44 Knoll Rd., Edgewood  
 Conrad, Mrs. Ernest M.  
     2124 Meridian Street  
 Dixon, Mrs. Rex W. 936 W. 8th  
 Donaldson, Mrs. Frank C.  
     1728 W. 10th  
 Drake, Mrs. John C.  
     Madison Heights  
 Ellis, Mrs. Seth W. Forest Hills  
 Elsten, Mrs. Wayne A.  
     1333 Maryland Dr., Forest Manor  
 Erehart, Mrs. Archie D.  
     1221 Irving Way  
 Fischer, Mrs. Warren E.  
     Grandview Terrace  
 Gante, Mrs. Henry W.  
     2005 Nichol  
 Hart, Mrs. Wm. D. 1026 W. 8th  
 Hensler, Mrs. Benton M.  
     717 Winding Way, Edgewood  
 Jones, Mrs. Albert T. 1930 W. 12th  
 Kelly, Mrs. Wendell C.  
     23 Colony Rd., Edgewood  
 King, Mrs. Barnard A.  
     26 Winding Way  
 King, Mrs. Joseph W.  
     260 Davis Drive, Edgewood  
 Larmore, Mrs. Joseph L.  
     1301 Winding Way, Edgewood  
 Litzenberger, Mrs. Sam W.  
     Forest Hills  
 Long, Mrs. Paul L. Forest Hills  
 McDonald, Mrs. Virgil C.  
     Country Club Estates  
 Metcalf, Mrs. George B. 830 W. 8th  
 Neale, Mrs. Alfred E.  
     630 Madison  
 Nesbitt, Mrs. Leonard L.  
     R.R. 6, Box 10, 8th Street Rd.  
 Patterson, Mrs. William K.  
     2747 Nichol  
 Polhemus, Mrs. Warren C.  
     1800 W. 11th  
 Rosenbaum, Mrs. Lloyd E.  
     Forest Hills  
 Ross, Mrs. Guy E.  
     Madison Heights  
 Rozelle, Mrs. Clarence V.  
     Forest Hills  
 Sharp, Mrs. William L.  
     Country Club Estates  
 Stamper, Mrs. Joseph H.  
     R. R. 7, Box 47  
 Swan, Mrs. Richard C. Forest Hills  
 Webb, Mrs. Harry D.  
     1308 Maryland Drive

Wilder, Mrs. Gordon B.  
     338 West 8th St.  
 Williams, Mrs. Robert H.  
     Country Club Estates  
 Wilkinson, Mrs. Roger L.  
     1525 Winding Way, Edgewood  
 Wishard, Mrs. Fred B. 505 W. 9th  
 Zierer, Mrs. Reuben O.  
     Woodlawn Heights

Drake, Mrs. Marion C. . . . Elwood  
 Scea, Mrs. Wallace A.  
     1402 S. F St., Elwood  
 Bishop, Mrs. Harry A. Frankton  
 Williams, Mrs. Robert D.  
     Markleville  
 Dickey, Mrs. Morris W. . . Pendleton  
 McLaughlin, Mrs. Calvin P.  
     Pendleton  
 Williams, Mrs. Francis M.  
     Pendleton  
 Van Ness, Mrs. William  
     Summitville

**MARION COUNTY**

Ramage, Mrs. Walter F.  
     244 S. 1st, Beech Grove  
 Tyner, Mrs. Harlan H. . . . Clayton

**Indianapolis****A**

Adkins, Mrs. Harold C.  
     250 W. Hampton Drive  
 Albertson, Mrs. Frank P.  
     5031 Rockville Rd.  
 Alvis, Mrs. Edmond O.  
     8000 Morningside Dr.  
 Anderson, Mrs. John T.  
     3605 Balsam, No. 21  
 Appel, Mrs. Richard H.  
     4465 Marcy Lane, No. 190  
 Arbogast, Mrs. John L.  
     3516 Carrollton  
 Arbuckle, Mrs. William E.  
     5326 E. St. Joseph St.

**B**

Bachmann, Mrs. Arnold J.  
     3239 Winfield  
 Bakemeier, Mrs. Otto H.  
     5535 E. St. Clair  
 Ball, Mrs. Joseph E. 823 N. Lesley  
 Bartley, Mrs. Max D.  
     5640 N. Pennsylvania St.  
 Batman, Mrs. Gordon W.  
     6906 N. Delaware  
 Baumeister, Mrs. Herbert E.  
     314 W. Hampton Drive  
 Beamer, Mrs. Parker R.  
     3560 Carrollton  
 Beasley, Mrs. Thos. J.  
     112 Berkley Rd.  
 Beaver, Mrs. Howard W.  
     303 E. Edgewood Ave.  
 Beck, Mrs. Evart M.  
     1220 Oak Ridge Drive  
 Becker, Mrs. Harry G.  
     5641 Haverford Ave.  
 Beeler, Mrs. John W. 39 E. 39th St.  
 Berman, Mrs. Jacob K.  
     1105 W. Kessler Blvd.  
 Bibler, Mrs. Lester D.  
     4360 N. Pennsylvania  
 Blatt, Mrs. A. Ebner  
     5330 N. Illinois  
 Boling, Mrs. Grover C.  
     3308 N. Manor Court

Bowman, Mrs. George W.  
     5634 Carrollton  
 Boyer, Mrs. Floyd A.  
     136 S. Wittfield  
 Brady, Mrs. Thomas A.  
     225 Wellington Rd.  
 Brayton, Mrs. John R.  
     3128 E. Fall Creek Blvd.  
 Brayton, Mrs. Lee  
     5540 N. Illinois  
 Brodie, Mrs. Donald W.  
     R.R. 12, Box 241 M  
 Brown, Mrs. Edward A.  
     5420 Central  
 Brown, Mrs. Wendell,  
     3750 N. Gale  
 Browning, Mrs. William M.  
     2275 Wynnedale Rd.  
 Brubaker, Mrs. E. H. . 624 E. 23rd  
 Bunde, Mrs. Carl A.  
     952 N. Downey  
 Burghard, Mrs. Rolla 2171 E. 67th  
     C  
 Cahal, Mrs. Ernest E. . . 27 E. 39th  
 Cahn, Mrs. Hugo M. . . . 3038 Park  
 Call, Mrs. Herbert F. . 710 E. 57th  
 Carson, Mrs. E. Wayne,  
     7177 N. Meridian  
 Carter, Mrs. Larue D.  
     4280 N. Meridian  
 Carter, Mrs. Oren E.  
     5461 Kenwood  
 Clark, Mrs. Lawson J.  
     2425 E. Kessler Blvd.  
 Cohn, Mrs. A. F. . 1120 S. View Dr.  
 Conley, Mrs. Joseph L.  
     1617 E. Ohio  
 Conway, Mrs. Glenn,  
     2235 E. Garfield Dr.  
 Cornacchione, Mrs. Matthew  
     4401 Carson Ave.  
 Cortese, Mrs. James V.  
     124 W. Troy  
 Cortese, Mrs. Thomas A.  
     3240 Brill Rd.  
 Countryman, Mrs. F. W.  
     5633 Central  
 Cox, Mrs. Clifford E.  
     R. R. 14, Box 811  
 Culbertson, Mrs. C. G.  
     6060 Park Ave.  
 Cuthbert, Mrs. Marvin  
     6935 N. Penn. St.

**D**

Davidson, Mrs. N. Cort  
     6901 Washington Blvd.  
 Davis, Mrs. John A.  
     3720 N. Sherman Drive  
 Davis, Mrs. Sam J. 4545 Broadway  
 Day, Mrs. Clark. 228 W. 44th St.  
 Dearmin, Mrs. Robert M.  
     5147 N. Delaware  
 DeArmond, Mrs. Albert M.  
     5401 N. Delaware  
 Deever, Mrs. John W.  
     6801 S. East St.  
 Denny, Mrs. James W.  
     84 N. Audubon Rd.  
 DeWees, Mrs. Dwight L.  
     302 N. Bradley  
 Donato, Mrs. Albert M.  
     4225 South East  
 Dorman, Mrs. W. Leland  
     2005 Lick Creek Drive  
 Dugan, Mrs. William M.  
     5747 Rolling Ridge Rd.  
 Dyar, Jr. Mrs. Edwin W.  
     5910 Washington Blvd.

**MARION COUNTY**  
(Indianapolis—Continued)

**E**

Eastman, Mrs. Joseph R., Jr.  
8217 Spring Mill Rd.  
Eastman, Mrs. Joseph Rilus  
8160 N. Meridian  
Eaton, Mrs. Edwin R.  
5750 Allisonville Rd.  
Ebert, Mrs. J. Wayne  
1125 Southview Dr.  
Egbert, Mrs. Herbert L.  
419 W. 63rd St.  
Eicher, Mrs. Palmer O.  
4401 Washington Blvd.  
Eldridge, Mrs. Gail E.  
5746 Central  
Ellis, Mrs. Bert E. R. R. 18, Box 32  
Emhardt, Mrs. John T.  
3305 Brill Rd.  
Emhardt, Mrs. John W.  
5424 Washington Blvd.  
Ensminger, Mrs. Leonard A.  
1321 N. Meridian  
Ernst, Jr. Mrs. Clifford E.  
3206 N. Sharon  
Evans, Mrs. Paul V.  
5725 Indianola  
Everly, Mrs. Ralph V. 1105 E. 58th

**F**

Fausset, Mrs. C. Basil  
7757 N. Meridian  
Fisher, Mrs. Albert A.  
1130½ S. Belmont  
Flanigan, Mrs. Meridith B.  
2920 W. 33rd  
Flora, Mrs. Joseph O.  
5604 Rockville Road  
Folkening, Mrs. Norval C.  
5501 Camden  
Frazin, Mrs. Bernard 1481 W. 10th  
Fouts, Mrs. Paul J. 8393 N. Illinois  
Freeman, Mrs. Max E.  
326 N. Mount St.  
Fry, Mrs. Robert D.  
5717 Broadway

**G**

Gabe, Mrs. William E.  
502 W. Hampton Dr.  
Gambill, Mrs. Wm. Dudley  
2272 Wynnedale  
Garber, Mrs. J. Neill, 1101 E. 57th  
Garceau, Mrs. George J.  
4334 N. Pennsylvania  
Gardner, Mrs. F. Buckman  
315 W. Hampton Dr.  
Garner, Mrs. W. Stanley  
3785 E. 62nd  
Garrett, Mrs. Robert A.  
5242 Boulevard Place  
Gastineau, Mrs. David C.  
8620 Manderley Dr.  
Gastineau, Mrs. Frank M.  
5344 N. Pennsylvania  
Geider, Mrs. Roy A.  
5816 Pleasant Run Pkwy.  
Gick, Mrs. Herman H.  
451 Eastern  
Gifford, Mrs. Fred E.  
5125 N. Meridian  
Gillespie, Mrs. Charles F.  
2615 E. 35th  
Goldman, Mrs. Samuel  
5632 Rosslyn  
Gosman, Mrs. James H.  
320 E. 38th St., No. 312

Greist, Mrs. John H.  
4343 Washington Blvd.  
Griffith, Mrs. Harold B.  
6134 Indianola Ave.  
Griffith, Mrs. Richard S.  
1676 Winton  
Griffith, Mrs. Ross E.  
4452 Washington Blvd.  
Grisell, Mrs. Ted L.  
5411 Broadway  
Gustafson, Mrs. Gerald W.  
5768 N. Pennsylvania

**H**

Habich, Mrs. Carl 44 E. 52nd  
Hadley, Mrs. David  
5601 N. Pennsylvania  
Haggard, Mrs. Edmund B.  
3481 Birchwood  
Hahn, Mrs. E. Vernon  
R. R. 18, Box 376  
Hall, Mrs. Frank  
8633 N. Pennsylvania  
Hall, Mrs. Jack R.  
4061 Washington Blvd.  
Hamer, Mrs. Homer G.  
4454 N. Pennsylvania  
Hampshire, Mrs. Donald  
4378 Central  
Hanley, Mrs. Edward J.  
5260 Ralston  
Hann, Mrs. E. C.  
4217 N. Lesley Ave.  
Hansell, Mrs. Robert M.  
3525 N. Gladstone  
Harcourt, Mrs. Allan K.  
4915 N. Illinois  
Harding, Mrs. M. Richard  
4220 DeVon Court  
Harding, Mrs. Myron S.  
46 W. 46th  
Harold, Mrs. Albert H.  
7510 Allisonville Rd.  
Harold, Mrs. Norris E.  
3545 N. Denny  
Haslinger, Mrs. Clarence J.  
5236 Boulevard Place  
Hawk, Mrs. James H.  
4485 N. Pennsylvania  
Haymond, Mrs. Joseph L.  
551 E. 36th  
Hays, Mrs. Everett L.  
2607 Manker  
Hendricks, Mrs. John W.  
124 W. 64th St.  
Helmer, Mrs. O. M.  
5015 N. Illinois  
Hendricks, Mrs. John W.  
124 W. 64th  
Hepburn, Mrs. Charles K.  
7570 Morningside Dr.  
Hetherington, Mrs. A. M.  
445 E. 71st St.  
Heubi, Mrs. John E.  
5061 N. Illinois  
Hickman, Mrs. Walter F.  
6030 Gladden Drive  
Hilldrup, Mrs. Don G.  
5672 N. Illinois  
Holman, Mrs. Jerome E., Jr.  
5930 Central Avenue  
Holman, Mrs. Jerome E., Sr.  
4503 Kessler Blvd., E.Dr.  
Hood, Mrs. Ainslee A.  
5059 S. Harlan  
Horwitz, Mrs. Thomas  
6720 Allisonville Rd.  
Howell, Mrs. Joseph D.  
3431 Winthrop

Howell, Mrs. Robert D.  
3641 N. Pennsylvania  
Huddle, Mrs. John R.  
5812 N. Hillside  
Hudson, Mrs. Foster J.  
525 W. Hampton Dr.  
Hughes, Mrs. James E.  
2534 Broadway  
Hughes, Mrs. William F., Sr.  
4025 N. Meridian  
Hull, Mrs. Ronald 2220 Douglas

**I-J**

Irwin, Mrs. Glenn W., Jr.  
5022 Graceland  
Jaeger, Mrs. Alfred S.  
2935 Washington Blvd.  
Jaquith, Mrs. Orville S.  
261 Blue Ridge Rd.  
Jay, Mrs. Arthur N. 815 W. 64th  
Jennings, Mrs. Frank  
2601 Cold Springs Road  
Jewett, Mrs. Joe H. 4907 Rosslyn  
Jinks, Mrs. Clifford H.  
5740 Carrollton  
Johnson, Mrs. Thomas W.  
5735 Washington Blvd.  
Jones, Mrs. Allen W.  
2530 E. 58th St.  
Joseph, Mrs. Rex M.  
620 Hickory Lane

**K**

Kahle, Mrs. Dan B.  
5161 Primrose Ave.  
Kammen, Mrs. Leo 257 W. 46th  
Kammen, Mrs. Robert  
1905 Patton Drive  
Katterjohn, Mrs. James  
5867 Central Ave.  
Keenan, Mrs. Reid L.  
3702 N. Delaware  
Keiser, Mrs. V. D. 5709 Broadway  
Kelly, Mrs. Don E. 4927 Kenwood  
Kelly, Mrs. Walter F.  
6845 E. Pleasant Run Pkwy.  
Kelly, Mrs. William M.  
6685 E. Pleasant Run Pkwy.  
Kempf, Mrs. Gerald F.  
General Hospital  
Kennedy, Mrs. Hunter  
757 N. Bolton  
Kerr, Mrs. Harry R.  
5774 Washington Blvd.  
Kime, Mrs. Edwin N.  
239 Buckingham Dr.  
Kingsbury, Mrs. John K.  
5776 E. Michigan  
Kirklin, Mrs. Oren L.  
8005 Englewood Rd.  
Kirtley, Mrs. Wm. R. 730 E. 73rd  
Kiser, Mrs. Edgar F. 5610 Central  
Kitterman, Mrs. Harry E.  
5108 Graceland  
Klain, Mrs. Benjamin V.  
5775 Central  
Knowles, Mrs. Charles Y.  
1121 N. Downey  
Knowles, Mrs. Robert P.  
7435 Central Avenue  
Kohlstaedt, Mrs. Kenneth G.  
645 E. 80th  
Koons, Mrs. Karl M. 5767 N. Penn.  
Kornafel, Mrs. L. H. 6201 College  
Kraft, Mrs. Bennett  
7025 Washington Blvd.  
Kuntz, Mrs. Herman W.  
1418 N. Butler



### MARION COUNTY (Indianapolis—Continued)

Kurtz, Mrs. Philip L.  
6841 Willow Rd.  
Kwitney, Mrs. I. J.  
5774 Broadway Terrace

#### L

LaDine, Mrs. Clarence B.  
4221 E. 35th  
Lamb, Mrs. Emmett B.  
1180 Golden Hill Dr.  
Lamb, Mrs. Russell W.  
4636 N. Capitol  
Lamber, Mrs. Chet K.  
1501 E. Maple Rd., Apt. 19  
Laramore, Mrs. Ward  
5835 N. Keystone  
Lawler, Mrs. George F.  
5601 E. St. Clair  
Leasure, Mrs. J. Kent  
3115 N. Meridian  
Leff, Mrs. Abe H. . . . 46 W. 52nd  
Leffler, Mrs. W. T. . . 5515 N. Illinois  
Levi, Mrs. Leon  
402 W. Hampton Dr.  
Lewis, Mrs. Robert J.  
3742 N. Denny  
Lichtenberg, Mrs. Melvin  
5677 N. Meridian  
Lingeman, Mrs. R. E.  
3845 N. Meridian  
Link, Mrs. Goethe  
2609 Putters Lane  
Little, Mrs. Wm. J. . . . 6215 Parker  
Lochry, Mrs. Ralph L.  
6150 Crows Nest Dr.  
Lord, Mrs. Glenn C.  
4455 Washington Blvd.  
Love, Mrs. George N.  
1644 N. Delaware  
Ludwig, Mrs. Oscar D.  
5433 Madison  
Luros, Mrs. J. Theodore  
5275 N. Capitol  
Lybrook, Mrs. William B.  
4585 Kessler Blvd., E. Dr.

#### M

McBride, Mrs. James S.  
720 E. 80th St.  
McCaskey, Mrs. Carl H.  
3545 Washington Blvd.  
McClain, Mrs. Edwin S.  
550 W. 77th St., N. Dr.  
McCown, Mrs. Percy E.  
5008 N. Meridian  
McGrath, Mrs. Michael F.  
6183 Washington Blvd.  
McGuff, Mrs. Paul  
3668 Central Ave.  
McIntire, Mrs. Clarence R.  
4520 Marcy Lane, No. 27  
McQuiston, Mrs. Ralph J.  
6120 Lawrence Drive  
McTurnan, Mrs. Robert W.  
5957 Kingsley Dr.  
MacGregor, Mrs. Donald E.  
6080 N. Michigan Rd.  
Mackey, Mrs. John E. . 629 E. 32nd  
Magennis, Mrs. Herbert L.  
3010 E. 38th, No. 14  
Manalan, Mrs. M. M.  
3007 E. 39th, No. 60  
Manion, Mrs. Marlow W.  
5132 N. New Jersey  
Mann, Mrs. Mortimer . . 28 E. 55th

Manzie, Mrs. Michael W.  
2687 W. 44th St.  
Marshall, Mrs. Albert L. Jr.  
4149 Central Ave.  
Marshall, Mrs. Cavins R.  
6120 N. Michigan Rd.  
Martin, Mrs. Loren H.  
5338 Washington Blvd.  
Martz, Mrs. Carl D.  
4571 Fall Creek Blvd., S. Dr.  
Masters, Mrs. John M. . 34 E. 46th  
Matthew, Mrs. W. Burleigh  
3462 E. Fall Creek Blvd., N. Dr.  
Matthew, Mrs. William  
1122 N. Bolton Ave.  
Megenhardt, Mrs. Dennis  
3038 E. Fall Creek Blvd.  
Mericle, Mrs. Earl W.  
4480 N. Meridian  
Merrell, Mrs. Paul  
5637 Kenwood  
Mertz, Mrs. John H. O.  
723 Clarendon Pl.  
Micheli, Mrs. Arthur J.  
1501 E. 38th, No. 3  
Miller, Mrs. Raleigh S.  
6140 College  
Mitchell, Mrs. Earl H.  
2263 E. Riverside Dr.  
Mitchell, Mrs. Edward O.  
6144 N. Dearborn St.  
Moenning, Mrs. Walter P.  
7030 N. Pennsylvania  
Molt, Mrs. William F.  
2315 N. Talbot  
Montgomery, Mrs. William F.  
4546 Park  
Moore, Mrs. Harold T. 3220 Sharon  
Moore, Mrs. Robert M.  
5617 N. Meridian  
Morchan, Mrs. Samuel  
7007 Broadway  
Morrison, Mrs. Lewis E., II  
4450 Park Ave.  
Morton, Mrs. Walter P.  
3434 E. Fall Creek Blvd., N. Dr.  
Muller, Mrs. L. P.  
5608 College Ave.  
Myers, Mrs. Roy V.  
4450 E. Kessler Blvd.

#### N

Nafe, Mrs. Cleon 5060 N. Meridian  
Nagan, Mrs. Robert F.  
1434 N. Delaware, No. 28  
Nay, Mrs. Richard M.  
5525 N. Meridian  
Need, Mrs. Louis T. . . 3627 Bluff Rd.  
Nester, Miss Lena Laura  
2832 N. Capitol  
Nie, Mrs. Louis W. . . . 4305 Central  
Noble, Jr., Mrs. Thomas B.  
5556 N. Meridian  
Nolting, Mrs. Henry F.  
155 W. Hampton Dr.  
Norris, Mrs. Max S.  
21 W. 28th St., No. 4  
Nourse, Mrs. Myron 5251 Primrose  
Nugent, Mrs. Edwin J.  
6840 N. Delaware St.

#### O

Ochsner, Mrs. Harold C.  
405 E. 45th  
Olvey, Mrs. Ottis N.  
5428 Central Ave.  
Otten, Mrs. Claude F. 4456 Central  
Owen, Mrs. John E. 4429 N. Illinois  
Owens, Mrs. Tracy  
2823 N. Meridian

#### P

Pandolfo, Mrs. Harry  
529 Markwood  
Patton, Mrs. Martin T.  
3060 N. Meridian, Apt. 504  
Paulissen, Mrs. George T.  
741 Markwood  
Paynter, Mrs. Morris B.  
115 Roberts Road  
Pearson, Mrs. Lyman R.  
Marott Hotel, No. 624  
Peck, Mrs. Franklin B.  
5826 Winthrop  
Pennington, Mrs. Walter E.  
4420 N. Meridian  
Permer, Mrs. Erwin  
3018 N. Delaware  
Peters, Mrs. Robert J. D.  
3203 E. Michigan  
Petranoff, Mrs. T. V.  
2814 Questend St.  
Pilcher, Mrs. Jack E.  
4601 Graceland Ave.  
Poppewell, Mrs. A. G.  
Sunnyside Sanatorium  
Price, Mrs. Francis W.  
2405 Union  
Price, Mrs. James O.  
7015 College Ave.  
Pryor, Mrs. Richard  
6134 Carrollton

#### R

Rabb, Mrs. Albert M.  
4146 N. Illinois  
Rader, Mrs. George S. 3778 E. 62nd  
Ramsey, Mrs. Frank B.  
R. 17, Box 161  
Reed, Mrs. Phillip B.  
4131 N. Meridian  
Rees, Mrs. Russell C.  
926 Ellenberger Pkwy., W. Dr.  
Reid, Mrs. Charles A.  
6506 Madison Ave.  
Rice, Mrs. Frederick A., Jr.  
3423 N. Grant  
Rice, Mrs. Raymond M.  
5365 N. New Jersey  
Richardson, Mrs. Thad T.  
408 N. Arlington  
Ricketts, Mrs. Joseph W.  
5349 Kenwood  
Rigg, Mrs. John F.  
5115 N. Meridian  
Ritchey, Mrs. James O. 43 W. 43rd  
Robb, Mrs. John A. 5254 Broadway  
Rogers, Mrs. Donald L.  
3031 N. Centennial  
Rohn, Mrs. Robert J.  
3740 Forest Manor Ave.  
Roller, Mrs. Charles W.  
2301 Garfield Dr.  
Romberger, Mrs. Floyd T. Jr.  
370 W. 52nd  
Rosenak, Mrs. Bernard D.  
5254 N. Delaware  
Rosenbaum, Mrs. David  
3930 Broadway  
Ross, Mrs. Alexander T.  
265 W. Westfield Blvd.  
Ruddell, Mrs. Karl R.  
2626 N. Meridian  
Rupel, Mrs. Ernest  
701 Kessler Blvd., W. Dr.  
Rust, Mrs. Byron K.  
8120 Sycamore Rd.  
Ryan, Mrs. Glen V.  
3168 E. Fall Creek Pkwy., N. Dr.



### MARION COUNTY (Indianapolis—Continued)

#### S

Sage, Mrs. Russell A.  
8650 College Ave.

Salb, Mrs. Max C.  
6741 Allisonville Rd.

Sanders, Mrs. Harry M.  
4330 Forest Manor Ave.

Schechter, Mrs. John  
4966 Kingsley Dr.

Schlegel, Mrs. Donald M.  
6123 Oakland Ave.

Schmidt, Mrs. Loren F.  
2909 E. 37th St.

Schneider, Mrs. Carl J.  
340 N. Kenyon

Schuchman, Mrs. Gabriel  
5944 Central

Schuster, Mrs. Dwight  
5042 N. Capitol

Scott, Mrs. George E.  
3636 Layman

Scott, Mrs. John R.  
112 Blue Ridge Road

Scott, Mrs. Robert P.  
5011 Winthrop Ave.

Sedam, Mrs. Herbert L.  
6931 Central

Sexson, Mrs. Hiram T.  
5455 N. Meridian

Shafer, Mrs. Marion R.  
6290 Allisonville Rd.

Sheehan, Mrs. Francis G.  
950 Graham

Shumacker, Mrs. H. B. Jr.  
4330 N. Central

Sicks, Mrs. Okla  
5609 N. Pennsylvania

Sidebottom, Mrs. Earl W.  
2820 W. 29th

Siekerman, Mrs. C. W.  
1604 Loretta

Sigmond, Mrs. Harvey W.  
3245 N. Pennsylvania

Sims, Mrs. J. Lawrence  
3723 N. Gale

Sluss, Mrs. David  
3657 Washington Blvd.

Smith, Mrs. Edward B.  
3429 Guilford Ave.

Smith, Mrs. E. Rogers  
4725 Central Ave.

Smith, Mrs. Lester A.  
126 Berkley Rd.

Smith, Mrs. Roy Lee  
R. R. 6, Box 473

Solomon, Mrs. R. A.  
5330 N. Pennsylvania

Sovine, Mrs. J. W.  
8182 N. Illinois

Spahr, Mrs. John F. Jr.  
3014 Green Hills Lane, N. D.

Sparks, Mrs. Alan L.  
4310 Central

Spaulding, Mrs. Joe J.  
112 W. 44th St.

Sputh, Mrs. C. B. Jr.  
5671 Rolling Ridge Rd.

Sputh, Mrs. Carl B. Sr.  
7860 Barlum Dr.

Stadler, Mrs. Harold E.  
6244 Washington Blvd.

Stanley, Mrs. John  
3814 E. 30th

Stayton, Mrs. Chester A. Sr.  
6925 N. Delaware

Stephens, Mrs. Kuhrman H.  
5210 Boy Scout Road

Sterne, Mrs. S. Gloria  
410 N. Meridian St.

Stevens, Mrs. Sydney L.  
3430 N. Temple

Stoelting, Mrs. V. K.  
3730 N. Gale

Stone, Mrs. A. T.  
5727 Broadway

Storey, Mrs. D. Edmund  
4535 Marcy Lane, Apt. 258

Stroup, Mrs. Tyler J.  
5758 College

Stucky, Mrs. Elsworth K.  
4528 N. Meridian

Stygall, Mrs. James H.  
4311 N. Meridian

Sudranski, Mrs. Herbert F.  
3614 Guilford

Sutton, Mrs. William E.  
5670 Guilford

Swan, Mrs. John R.  
320 Arden Dr.

Symmes, Mrs. Alfred T.  
717 W. 44th

Szynal, Mrs. John S.  
1841 Warman

#### T

Talbott, Mrs. Dan E.  
6470 N. Michigan Rd.

Tanner, Mrs. Henry S.  
4461 N. Pennsylvania

Taylor, Mrs. Clifford  
5938 Crittenden

Taylor, Mrs. Frederick W.  
40 E. 43rd

Teague, Mrs. Frank W.  
8000 Sycamore Rd.

Tether, Mrs. J. Edward  
2206 Lafayette Rd.

Tharpe, Mrs. Ray  
6161 Sunset Lane

Thatcher, Mrs. Hugh K. Jr.  
745 W. 44th

Thomas, Mrs. Lowell L.  
28 W. Hampton Dr.

Thomas, Mrs. Morris E.  
5207 N. New Jersey

Thompson, Mrs. Charles F.  
6038 N. Olney

Thompson, Mrs. John V.  
7899 Ridge Rd.

Thornburg, Mrs. K. E.  
4702 Washington Blvd.

Thurston, Mrs. A. L.  
421 E. 41st

Tindall, Jr., Mrs. G. T.  
964 Ellenberger Pkwy., W. Dr.

Tinsley, Mrs. Walter B.  
3314 Carrollton

Torrella, Mrs. Jose A.  
5721 W. 18th

Trusler, Mrs. Harold M.  
6150 N. Pennsylvania

Tuchman, Mrs. Joseph H.  
1154 Hawk Lane

Tucker, Mrs. Warren S.  
5338 N. Pennsylvania

#### V

Vandivier, Mrs. Robert M.  
4738 Boulevard Pl.

Van Meter, Mrs. C. Powell  
4102 Marrison Place

VanOsdol, Mrs. Harry A.  
43 Hampton Drive

Vollrath, Mrs. Victor J.  
5204 N. Illinois

Voyles, Mrs. Charles F.  
4150 N. Meridian

#### W

Waldo, Mrs. J. Thayer  
8383 N. Illinois

Walker, Mrs. Frank C.  
5563 N. Pennsylvania

Walther, Mrs. Joseph E.  
4266 N. Pennsylvania

Warvel, Mrs. John H.  
4360 Kessler Blvd., N. Dr.

Weller, Mrs. Charles A.  
3720 N. Delaware St.

West, Mrs. Joseph L.  
2110 W. 38th

Westfall, Mrs. B. Kemper Jr.  
4001 N. Meridian

Westfall, Mrs. John B.  
32 E. 46th

White, Mrs. Donald J.  
5430 N. Delaware

White, Mrs. John B.  
6425 Lawrence Drive

Wilkens, Mrs. Irvin W.  
4816 Pleasant Run Pkwy.

Williams, Mrs. Howard S.  
3908 Guilford

Wilmore, Mrs. Ralph C.  
6015 Evanston

Wilson, Mrs. Oliver R.  
3519 Washington Blvd.

Winters, Mrs. Matthew  
4044 Carrollton

Wise, Mrs. William  
4934 N. Pennsylvania

Wise, Mrs. Wm. R.  
5004 N. Pennsylvania

Wishard, Mrs. William N. Jr.  
4150 N. Illinois

Wolfram, Mrs. Don J.  
5716 N. Pennsylvania

Wooling, Mrs. Kenneth R.  
5303 Blvd. Pl.

Worley, Mrs. J. P.  
6796 E. 10th Street

Wright, Mrs. J. William Jr.  
2115 Wilshire Rd.

Wytenbach, Mrs. John E.  
5509 Kenwood

#### Y-Z

Yochem, Mrs. August S., Jr.  
3015 Medford Ave.

Young, Mrs. James W.  
440 E. 71st

Young, Mrs. John M.  
4525 Marcy Lane

Young, Mrs. Woodson C.  
3215 Medford

Zell, Mrs. Evertson H.  
3110 Sutherland Ave.

Miller, Mrs. Ray D.  
290 E. Washington, Martinsville  
New Augusta

Asher, Mrs. Ernest O. . . . . Box 4

Asher, Mrs. James W.

Brown, Mrs. David E. . . . . R. R. 1

Brown, Mrs. DeWitt W.  
R. R. 1, Box 268

Spivey, Mrs. Russell J. . . . . R. R. 1

Jones, Mrs. George L. Wanamaker  
Bailey, Mrs. Lawrence S.  
110 S. Second, Zionsville

### MARSHALL COUNTY

Graham, Mrs. C. R. . . . . Bourbon

Bowen, Mrs. Otis R. . . . . Bremen

Reed, Mrs. Donald . . . . . Culver

Reese, Mrs. L. W. . . . . Culver

#### Plymouth

Danielson, Mrs. Harry L.

Klingler, Mrs. M. O.  
1111 Ferndale Ave.

Kubley, Mrs. James  
624 E. LaPorte St.

**MARSHALL COUNTY**  
(Plymouth—Continued)

Pomeroy, Mrs. Rex. 1400 Park Ave.  
 Reed, Mrs. Robert G. . . . . 109 Baker  
 Robertson, Mrs. James  
     1010 Highland Ct.  
 Vore, Mrs. Loring W.  
     1801 N. Michigan

**MIAMI COUNTY**

Shrock, Mrs. E. E. . . . . Amboy  
 Line, Mrs. Homer. . . . . Chili  
     Macy  
 Sennett, Mrs. W. K.  
 Waite, Miss Carrie  
 Waite, Miss Margaret

Rendel, Mrs. C. F. . . . . Mexico  
 Rendel, Mrs. H. E. . . . . Mexico

**Peru**

Baldwin, Mrs. C. A.  
     17½ S. Huntington  
 Barnett, Helen. . . . . 109 W. 7th  
 Berkebile, Mrs. John. . . . . 15 W. 6th  
 Carl, Mrs. Clara. . . . . 128 W. 3rd  
 Daiani, Mrs. P. G. . . . . W. Main St.  
 Eikenberry, Mrs. B. F. . . . . 28 W. 6th  
 Freeze, Mrs. J. A. 213 E. Main St.  
 Herd, Mrs. C. R. . . . . 115 E. 5th  
 Johnson, Mrs. Owen B.  
     620 W. 5th St.  
 Malouf, Mrs. S. D. . . . . 359 W. 3rd  
 Wagner, Mrs. Sarah. . . . . R. R. 4  
 Wildman, Mrs. R. E. . . . . R. R. 2  
 Yarling, Mrs. Francis. . . . . 117 E. 5th

**MONTGOMERY COUNTY****Crawfordsville**

Ball, Mrs. T. Z. 401 S. Washington  
 Burks, Mrs. Jess E. 411 S. Walnut  
 Cooksey, Mrs. Thomas L.  
     206 Marshall  
 Cornell, Mrs. Robert A.  
     1000 S. Washington  
 Daugherty, Mrs. Fred N.  
     415 W. Main  
 Haller, Mrs. Thomas C.  
     508 W. Main  
 Humphreys, Mrs. John W.  
     206 Woodlawn  
 Kinnaman, Mrs. Howard A. R. R. 6  
 Kirtley, Mrs. James M.  
     615 Thornwood Rd.  
 Lingeman, Mrs. Byron J.  
     203 Wallace  
 Mount, Mrs. William M.  
     1417 W. Main  
 Peacock, Mrs. Norman F.  
     107 Vernon Court  
 Pierson, Mrs. Robert H.  
     305 E. Main  
 Sharp, Mrs. John L. 1403 E. Main  
 Wallace, Mrs. Hawthorne C.  
     107 W. Jefferson  
 Otten, Mrs. Ralph R. . . . . Darlington  
 Priebe, Mrs. Fred. . . . . Hillsboro  
 Smith, Mrs. Byron J. . . . . Kingman  
     Ladoga  
 Blix, Mrs. Fred  
 Denny, Mrs. Frank T.  
 Walterhouse, Mrs. H. H.  
     New Market  
 Davis, Mrs. William H.  
     New Richmond  
 Kindell, Mrs. Herschel D.  
     New Richmond  
 Gwaltney, Mrs. L. F. . . . . Roachdale

Richards, Mrs. Edgar E. . . . . Russellville  
 Rusk, Mrs. Hubert M. . . . . Wallace  
 Johnson, Mrs. Dale. . . . . Waynetown  
 Parker, Mrs. Carl B. . . . . Wingate

**MORGAN COUNTY****Martinsville**

Eisenberg, Mrs. David  
     340 E. Cunningham  
 Gray, Mrs. Leon. . . . . 260 N. Ohio  
 Miller, Mrs. Ray  
     290 E. Washington  
 Pitkin, Mrs. McKendree C.  
     440 E. Washington  
 Sweet, Mrs. Austin. 260 N. Wayne  
 Van Wienan, Mrs. John  
     189 S. Jefferson  
 Willan, Mrs. Horace R.  
     109 S. Jefferson

**Mooreville**

Bivin, Mrs. James H.  
 Comer, Mrs. C. W.  
 Comer, Mrs. Kenneth  
 Karpel, Mrs. Bernard  
 VanBokkelen, Mrs. Robert

Murphy, Mrs. M. G. . . . . Morgantown

**NORTHEASTERN  
ACADEMY****Albion**

Bowman, Mrs. Charles M.  
 Nash, Mrs. Justin R.

**Angola**

Barton, Mrs. Robert  
 Hartman, Mrs. John

Geyer, Mrs. Joseph. . . . . Ashley  
 Hippensteel, Mrs. Harland

**Auburn**

Rogers, Mrs. E. E. . . . . Auburn  
 Mattmiller, Mrs. E. Dale. . . . . Avilla  
 Sneary, Mrs. Kenneth D. . . . . Avilla  
 DeVoe, Mrs. Kenneth. . . . . Butler  
 Hathaway, Mrs. Clayton. . . . . Butler  
 Weirich, Mrs. Charles L. . . . . Butler

**Garrett**

Jinnings, Mrs. Loren E.  
 Kantzer, Mrs. Floyd B.  
 Novy, Mrs. Charles  
 Reynolds, Mrs. D. Monroe  
 Reynolds, Mrs. Russel P.

**Kendallville**

Bryan, Mrs. Robert E.  
 Gutstein, Mrs. Richard R.  
 Hardy, Mrs. F. C.  
 Hepner, Mrs. Herman  
 Lawson, Mrs. Isaac H.  
 Messer, Mrs. Frank  
 Munk, Mrs. Cleorie E.  
 Seybert, Mrs. Joseph D.  
 Stallman, Mrs. Earl  
 Williams, Mrs. Harold O.

Alford, Mrs. James. . . . . Hamilton  
 Wade, Mrs. Alfred A. . . . . Howe  
 Studebaker, Mrs. Lloyd LaGrange  
 Schutt, Mrs. James B. . . . . Ligonier  
 Stultz, Mrs. Quentin F. . . . . Ligonier  
 Webster, Mrs. Paul. . . . . Ligonier  
 Fipp, Mrs. August L. . . . . Rome City  
 Lehman, Mrs. Kenneth. . . . . Topeka  
 Coleman, Mrs. Floyd. . . . . Waterloo  
 Showalter, Mrs. John P. . . . . Waterloo  
 Luckey, Mrs. Robert. . . . . Wolf Lake

**ORANGE-WASHINGTON  
COUNTIES**

Tower, Mrs. T. Kermit  
     Campbellsburg  
 Colglazier, Mrs. Granville G.  
     Leipsic  
 Paynter, Mrs. Wm. T. . . . . Pekin  
 Miller, Mrs. H. L. . . . . West Baden

**Orleans**

Baker, Mrs. Robert E.  
 Hodgin, Mrs. Phillip T.  
 Schoolfield, Mrs. Wm. E.

**Paoli**

Clark, Mrs. Ivan A.  
 Hammond, Mrs. Keith  
 Spears, Mrs. John K.

**Salem**

Apple, Mrs. E. R.  
 Episcopo, Mrs. A. R.  
 Gilliatt, Mrs. James P.  
 Huckleberry, Mrs. Irvin E.  
 Mitchell, Mrs. J. I.  
 Paynter, Mrs. L. W.

**OWEN-MONROE  
COUNTIES****Bloomington**

Borland, Mrs. Ray. . . . . Moores Pike  
 Buckingham, Mrs. Richard E.  
     705 S. Fess

Estes, Mrs. Ambrose  
     701 Highland Ave.  
 Fowler, Mrs. Ross. . . . . 709 Anita  
 Geiger, Mrs. Dillon. . . . . N. Fee Lane  
 Hardtke, Mrs. Eldred F.

**1005 S. Hawthorne Dr.**

Holland, Mrs. D. J. . . . . 1100 Atwater  
 Holland, Mrs. Philip

**514 N. College**

Karsell, Mrs. Wm. A. 700 Highland  
 Link, Mrs. William. . . . . Alice Ave.  
 Lyons, Mrs. Robert

**Smithville Rd.**

Marchant, Mrs. Clarence  
     350 S. College  
 Middleton, Mrs. Thomas O.  
     404 E. 7th St.

Pizzo, Mrs. Anthony. 409 S. Swain  
 Poolitsan, Mrs. George. 619 E. 9th  
 Quarles, Mrs. E. Bryan  
     811 S. Woodlawn

Ramsey, Mrs. Hugh. . . . . 619 E. 1st  
 Reed, Mrs. Wm. . . . . 1215 Atwater  
 Reiger, Mrs. I. Taylor  
     517 North Fess Ave.

Rogers, Mrs. Floyd. . . . . 804 E. 8th  
 Rollins, Mrs. Thomas  
     815 South Rose

Ross, Mrs. Ben. . . . . Martinsville Rd.  
 Schell, Mrs. H. D. . . . . 801 E. 7th  
 Sibbitt, Mrs. J. W.

**818 Sheridan Drive**

Smith, Mrs. Herschel  
     Martinsville Rd.  
 Smith, Mrs. Paul. . . . . 812 N. College  
 Stangle, Mrs. Wm. . . . . 1818 E. 3rd  
 Topolpus, Mrs. James  
     1015 Atwater

Wilson, Mrs. T. L. . . . . Nashville Rd.

Mitchell, Mrs. George L.  
     Smithville

**Spencer**

Blackwell, Mrs. Donald  
 Brown, Mrs. Marcel S.  
     358 N. Washington  
 Greene, Mrs. C. D. . . . . 215 N. Main  
 Smith, Mrs. F. R. 448 Lovers Lane



**PARKE-VERMILLION  
COUNTIES****Clinton**

Casebeer, Mrs. P. B. . . . . 844 S. 4th  
 Evans, Mrs. F. J. . . . . 1315 S. Main  
 Gerrish, Mrs. W. D. . . . . 125 S. Main  
 Herzberg, Mrs. Milton . . . . 545 S. 4th  
 Kercheval, Mrs. J. M. . . . . Box 192  
 Pickett, Mrs. Paul . . . . . 427 Whitcomb  
 White, Mrs. I. D. . . . . R. R.

Myers, Mrs. W. C. . . . . Dana  
 Bowman, Mrs. Ralph . . . . Marshall  
 Britton, Mrs. W. D. . . . . Montezuma  
 Saunders, Mrs. J. L. . . . . Newport  
 Johnson, Mrs. W. A. . . . . Perrysville  
 Bloomer, Mrs. J. R. . . . . N. Market  
 Bloomer, Mrs. R. S. . . . . W. York  
 Dowell, Mrs. E. H. . . . . 708 W. Ohio  
 Harstad, Mrs. C. . . . . W. High  
 Merrell, Mrs. Basil M. . . . .

516 S. Market St.  
 Pirkle, Mrs. H. B. State Sanitorium  
 Staff, Mrs. R. A. State Sanitorium

**PERRY-SPENCER  
COUNTIES**

Bush, Mrs. Hargis R. . . . .  
 6th St., Cannelton  
 Glackman, Mrs. J. C. . . . . Rockport

**Tell City**

Coultas, Mrs. P. J. . . . . 809 Main  
 Dome, Mrs. Hardin S. . . . . 704 9th  
 Dukes, Mrs. David A. . . . . 521 Main  
 Glenn, Mrs. F. C. . . . . 436 Main  
 James, Mrs. N. A. . . . . Upper 11th  
 Lally, Mrs. B. V. . . . . 622 Main  
 Lashley, Mrs. D. L. . . . . 606 9th  
 Lohoff, Mrs. Lewis C. . . . . 425 10th St.  
 Neifert, Mrs. Noel L. . . . . 1118 Blum

Snyder, Mrs. E. R. . . . . Troy

**PORTER COUNTY****Chesterton**

Griffin, Mrs. Joseph . . . . 134 Park Ave.  
 Hall, Mrs. Thomas . . . . Dune Acres  
 Harless, Mrs. C. M. . . . .  
 123 W. Indiana Ave.  
 Robertson, Mrs. W. C. . . . . 600 E. Morgan

**Valparaiso**

Brown, Mrs. J. C. . . . . 458 Park Ave.  
 Davis, Mrs. Carl . . . . . 202 Indiana  
 DeGrazia, Mrs. E. J. . . . . 157 McIntyre  
 Douglas, Mrs. George R. . . . .

404 Washington  
 Eades, Mrs. Ralph C. . . . .  
 501 E. Lincoln Way  
 Green, Mrs. Leonard . . . . 106 McKinley  
 Makovsky, Mrs. Theodore . . . . 902 Jefferson

Milroy, Mrs. Robert . . . . . 264 McIntyre Ct.  
 Poncher, Mrs. Henry . . . . R. R. 2  
 Vietzke, Mrs. Paul . . . . 60 Jefferson St.

Ashmore, Mrs. Herbert C. . . . Hebron

**PUTNAM COUNTY****Bainbridge**

Veach, Mrs. Lester W.  
 Veach, Mrs. Richard L.

Ellett, Mrs. John . . . . . Coatesville  
 Gray, Mrs. Clyde . . . . . Cloverdale

**Greencastle**

Dettloff, Mrs. Fredrick R. . . . .  
 201 W. Walnut  
 Dobbs, Mrs. O. D. . . . . R. R. 3  
 Fuson, Mrs. W. J. . . . .

108 Northwood Blvd.  
 Johnson, Mrs. James B. . . . .  
 314 Highfall Ave.

Rhea, Mrs. Gilbert D. . . . .  
 126 E. Washington  
 Schauwecker, Mrs. Cleon M. . . . .

613 Ridge Ave.  
 Steele, Mrs. Dick J. . . . .  
 207 Northwood Blvd.

Tennis, Mrs. George T. . . . .  
 602 S. Jackson  
 Tipton, Mrs. William R. . . . .

203 Northwood Blvd.  
 Wiseman, Mrs. V. Earle . . . . 6 Durham  
 Gwaltney, Mrs. L. F. . . . . Roachdale

**RANDOLPH COUNTY****Farmland**

Nixon, Mrs. Bryon . . . . . N. Main  
 White, Mrs. Harvey E. . . . . S. Main

**Lynn**

Harmon, Mrs. Wayne . . . . .  
 113 W. Church  
 Jordan, Mrs. Leo E. . . . .

209 W. Church  
 Slick, Mrs. Crystal R. . . . .  
 104 E. Sherman

Potter, Mrs. Richard M. . . . .  
 120 Walnut

**Union City**

Chambers, Mrs. Leroy B. . . . .  
 800 N. Columbus  
 Phipps, Mrs. Leland K. . . . .

516 N. Howard  
 Reid, Mrs. Robert W. . . . .  
 706 W. Division

Rothermel, Mrs. Harold . . . . .  
 729 N. Columbia  
 Voisinot, Mrs. R. A. . . . . 417 N. Howard

Wagner, Mrs. B. D. . . . .

Shallenberger, Mrs. H. R. . . . . Modoc

**Winchester**

Dininger, Mrs. W. S. . . . . 303 S. Main  
 Engle, Mrs. Russell B. . . . . R. R. 2  
 Painter, Mrs. Lowell W. . . . .

507 S. Main  
 Sparks, Mrs. Paul W. . . . . 601 W. Will

**RIPLEY COUNTY**

Hisrich, Mrs. L. W. . . . . Batesville  
 Lippoldt, Mrs. C. L. . . . . Batesville  
 Conrad, Mrs. Henry W. . . . . Milan

Hunter, Mrs. G. L. . . . . Milan  
 Williams, Mrs. Gilbert E. . . . . Milan  
 Daley, Mrs. Edward H. . . . . Oldenburg

Row, Mrs. George . . . . . Osgood  
 Smith, Mrs. Lee R. . . . . Osgood  
 McConnell, Mrs. William . . . . Sunman  
 Moran, Mrs. N. D. . . . . Versailles

**RUSH COUNTY**

McNabb, Mrs. George . . . . Carthage  
 McNabb, Mrs. Richard . . . . Carthage  
 Worth, Mrs. C. Willard . . . . Milroy

**Rushville**

Atkins, Mrs. C. C. . . . . 410 N. Perkins  
 Corpe, Mrs. Kenneth F. . . . . R. R. 4  
 Denny, Mrs. Melvin . . . . 124 E. 12th  
 Ellis, Mrs. Davis . . . . . 719 N. Perkin

Green, Mrs. Charles . . . . 912 N. Main  
 Green, Mrs. Frank . . . . 516 N. Morgan  
 Hoover, Mrs. Eugene . . . . 235½ W. 3rd

Johnson, Mrs. Robert I. . . . .  
 841 N. Harrison

Kay, Mrs. George . . . . 531 N. Perkins  
 Kennedy, Mrs. R. O. . . . 1004 N. Main  
 Kiplinger, Mrs. J. R. . . . 1301 N. Main

Lee, Mrs. John . . . . . 914 N. Morgan  
 Norris, Mrs. Marvin . . . . .

634 N. Morgan  
 Nutter, Mrs. W. H. . . . . R. R. 7  
 Shanks, Mrs. Roy E. . . . . 1110 N. Morgan

**SHELBY COUNTY**

Nigh, Mrs. R. M. . . . . Fairland  
 Davis, Mrs. John A. . . . . Flat Rock  
 Jean, Mrs. Thomas A. . . . . Morristown  
 Miller, Mrs. Frank H. . . . . Morristown

**Shelbyville**

Barnum, Mrs. Emerson . . . . .  
 110 E. Hendricks  
 Bass, Mrs. F. E. . . . .

169 W. Washington  
 Dalton, Mrs. Wilson L. . . . .  
 401 Sunset Dr.

Gehres, Mrs. Robert W. . . . 610 Shelby  
 Grove, Mrs. E. G. . . . .

242 W. Broadway  
 Inlow, Mrs. C. Fred . . . . .  
 48 E. Mechanic

Inlow, Mrs. Herbert H. . . . .  
 212 N. Harrison  
 Inlow, Mrs. W. D. . . . . Spring Hill Rd.

McFadden, Mrs. Walter C. . . . .  
 28 W. Mechanic  
 Miller, Mrs. R. C. . . . . 17 W. Mechanic

Phares, Miss Frances . . . . .  
 408 S. Harrison  
 Richard, Mrs. Norman F. . . . .

45 W. Washington  
 Scott, Mrs. V. B. . . . . R. R. 2  
 Silbert, Mrs. David B. . . . . 623 S. West

Spindler, Mrs. Robert D. . . . .  
 165 W. Mechanic  
 Tindall, Mrs. Paul R. . . . .

164 W. Franklin  
 Tindall, Mrs. W. R. . . . . 616 S. Harrison  
 Whitcomb, Mrs. Roger F. . . . .

413 W. South

**ST. JOSEPH COUNTY**

Thornton, Mrs. M. J. . . . .  
 R. R. 2, Bremen

**Mishawaka**

Ganser, Mrs. Richard A. . . . .  
 1020 Wilson Blvd.  
 Goethals, Mrs. C. J. . . . .

602 Lincolnway W.  
 McDonald, Mrs. R. M. . . . .  
 E. Jefferson Rd.

Orr, Mrs. W. Robert . . . . .  
 1335 Prospect Dr.  
 Proudfit, Mrs. C. H. . . . . 1135 E. 3rd

Reed, Mrs. Robert F. . . . .  
 2022 Linden Ave.  
 Sirlin, Mrs. Edward M. . . . .

R. R. 19, E. Jefferson Rd.  
 Spalding, Mrs. Wendell L. . . . .  
 617 Webster

Templeton, Mrs. Ames R. . . . .  
 522 Calhoun  
 Walerko, Mrs. Frank . . . . 626 Indiana

Walters, Mrs. Charles E. . . . .  
 111 S. Cedar



### ST. JOSEPH COUNTY (South Bend—Continued)

Whitlock, Mrs. Francis  
304 Lincoln Way E.  
Whitlock, Mrs. Merle E. 123 W. 4th  
Wurster, Mrs. H. C. . . . . 221 E. 3rd  
Wygant, Mrs. M. D. . . . . R. R. 1  
Wyland, Mrs. B. J. . . . . 510 Calhoun  
Zimmer, Mrs. H. J.  
333 Edgewater Drive

Bassler, Mrs. C. R.  
R. R. 4, Niles, Mich.  
Houser, Mrs. D. S.  
R. R. 2, Box 167, North Liberty  
Cline, Mrs. Kenneth L. . . . . Wyatt

**South Bend**

**A**  
Abel, Mrs. J. A. . . . . 825 W. Colfax  
Acker, Mrs. Robert B.  
103 S. Ironwood

**B**  
Balla, Mrs. Morris . . . 1516 E. Wayne  
Baran, Mrs. Charles . . . 128 Tasher  
Bechtold, Mrs. S. E. . . . 313 Pendle  
Bennett, Mrs. Jene R.  
1072 Woodward  
Berke, Mrs. Robt. D.  
2510 Erskine Blvd.  
Biasini, Mrs. B. A.  
149 Glendale Rd.  
Bickel, Mrs. David A.  
1335 E. Wayne St.  
Birmingham, Mrs. P. J.  
1126 E. Irvington  
Bixler, Mrs. Louis C. 1817 Portage  
Blackburn, Mrs. Erwin  
1343 E. LaSalle  
Bodnar, Mrs. Leslie M. . . 810 Arch  
Borough, Mrs. L. D. 1726 McKinley  
Bryan, Mrs. Robert J.  
604 E. Ewing  
Buchanan, Mrs. Wallace D.  
1351 E. South  
Buechner, Mrs. Fred W.  
603 W. Marion  
Bussard, Mrs. C. F.  
329 W. Madison  
Bussard, Mrs. Frank  
1332 E. Monroe

**C**  
Carter, Mrs. F. R. N.  
2000 E. Jefferson Blvd.  
Clark, Mrs. Stanley A.  
1242 E. Jefferson Blvd.  
Clark, Mrs. W. H.  
1336 E. Wayne, No.  
Colip, Mrs. George D. . . 300 David  
Condit, Mrs. D. H. . . . 1521 E. Wayne  
Cook, Mrs. Gordon C.  
1620 Southwood Ave.  
Custer, Mrs. Edward W.  
1111 Darden Rd.

**D**  
Denham, Mrs. Robert H.  
1429 E. Wayne  
Dietl, Mrs. Ernest L.  
216 S. Coquillard Dr.  
Dodd, Mrs. Robert D.  
1017 Kinyon St.  
Dolezal, Mrs. Bernard J.  
814 Turnock  
Donnelly, Mrs. Everett  
R. R. 6, Box 51B, Miami Rd.  
Duggan, Mrs. James A.  
110 Peashway

Dunlap, Mrs. D. Logan  
123 North Shore Dr.

**E**  
Ebin, Mrs. V. . . . . 2307 S. Olive  
Edwards, Mrs. Bernard E.  
1341 E. Wayne  
Egan, Mrs. Sherman L.  
944 Riverside Dr  
Ellison, Mrs. Alfred Dragoon Trail  
English, Mrs. J. Paul . . . 1317 Wall  
Erickson, Mrs. G. Walter  
209 Wildmere Dr.  
Erickson, Mrs. L. G.  
1212 E. Woodside

**F**  
Faltin, Mrs. L.  
302 S. Coquillard Dr.  
Feferman, Mrs. Martin  
1914 Rockne Dr.  
Filipek, Mrs. Walter  
2513 Lincoln Way West  
Firestein, Mrs. Ben Z.  
124 N. Eddy  
Firestein, Mrs. Ray  
2901 Miami St.  
Fish, Mrs. C. M. . . . . 119 Marquette  
Fish, Mrs. Edson C.  
1264 E. Colfax  
Fisher, Mrs. L. F. . . . 1717 E. Colfax  
Frank, Mrs. L. L.  
534 N. Lafayette Blvd.  
Frash, Mrs. D. W.  
1235 E. Wayne, So.  
Frey, Mrs. W. B.  
617 Northwood Dr.  
Friedman, Mrs. Morris S.  
1601 E. Cedar

**G**  
Gates, Mrs. George E.  
411 W. North Shore Dr.  
Giordano, Mrs. A. S. . . . 1222 25th  
Godersky, Mrs. George  
2744 Sampson  
Goraczewski, Mrs. T. C.  
1016 W. Washington  
Graff, Mrs. John P. . . . 424 Peashway  
Green, Mrs. George F.  
1515 E. Wayne  
Green, Mrs. Norvel E.  
1726 E. LaSalle  
Grillo, Mrs. Donald . . . 1832 N. Adams  
Gronrud, Mrs. Alton C.  
129 W. North Shore Dr.

**H**  
Hall, Mrs. James M.  
1416 E. Monroe  
Hamilton, Mrs. Charles O.  
1493 Northern  
Harmon, Mrs. V. E.  
3221 Mishawaka  
Haugseth, Mrs. E. K.  
407 S. 26th St.  
Helmer, Mrs. John . . . 1825 Wilbur  
Hilbert, Mrs. John W.  
410 W. Washington  
Hill, Mrs. Theodore  
1734 Portage Ave.  
Hillman, Mrs. Marion W.  
1516 Marquette Blvd.  
Hyde, Mrs. C. C. . . . . 1521 E. Colfax

**K**  
Kamm, Mrs. Bernard  
1402 E. Washington  
Karn, Mrs. John W.  
1444 Sunnymede

Klahr, Mrs. Ellsworth E.  
1422 McKinley  
Kramer, Mrs. John E.  
1206 N. Lawrence  
Krueger, Mrs. John E.  
1206 N. Lawrence

**L**  
Lane, Mrs. William H. . . 845 Park  
Lang, Mrs. Joseph E.  
505 Dixie Hwy., No.  
Langenbahn, Mrs. Carl J.  
1339 E. South  
Lionberger, Mrs. John R.  
1224 E. Wayne, No.  
Liss, Mrs. Emanuel  
1612 E. Madison

Liston, Mrs. Ann  
415 St. Joseph Bank Bldg.  
Lockhart, Mrs. Philip . . 409 S. 26th  
Lyons, Mrs. Robert C.  
2826 Southeast Drive

**M**  
McCraley, Mrs. W. J.  
2420 Erskine Blvd.  
Metcalf, Mrs. G. E.  
1209 E. Wayne, No.  
Miller, Mrs. Milo K.  
1714 E. Madison St.  
Murphy, Mrs. Eugene C.  
1411 Sunnymede

**N-O**  
Nelson, Mrs. Raymond E.  
1909 E. Madison  
Olson, Mrs. Kenneth  
1228 E. Woodside

**P**  
Parmly, Mrs. Walter E., Jr.  
1342 Mishawaka Ave.  
Parshall, Mrs. Dale . . . 2728 Hoke  
Pauszek, Mrs. Thomas B.  
916 Riverside Dr.  
Peltier, Mrs. Hubert  
416 Manchester Dr.  
Plain, Mrs. George  
2280 Ponader Dr.  
Potter, Mrs. Thomas P.  
1902 Marine

Pyle, Mrs. H. Dale  
115 N. Sunnyside

**R**  
Rigley, Mrs. Edward L.  
2161 Dixie Hwy., No.  
Rodin, Mrs. H. H.  
1138 E. Wayne, So.  
Rosenheimer, Mrs. George M.  
1425 E. Woodside  
Rubens, Mrs. Eli . . . 1331 E. Victoria

**S**  
Sandock, Mrs. I. . . . . 125 W. Marion  
Sandock, Mrs. Louis E.  
310 S. Sunnyside  
Sandoz, Mrs. H. H.  
239 S. Hawthorne Dr.  
Sandoz, Mrs. Louis A.  
304 S. Twyckenham Dr.  
Savery, Mrs. Charles E.  
1009 E. Jefferson, No. 6  
Schiller, Mrs. Herbert A.  
1813 E. Cedar  
Scott, Mrs. Frank M.  
1220 E. Woodside  
Selby, Mrs. K. E.  
1327 E. Wayne, No.  
Sensenich, Mrs. R. L. . . 123 S. Scott  
Spenner, Mrs. R. W.  
1015 Rockne Drive

**ST. JOSEPH COUNTY**  
**(South Bend—Continued)**

Stiver, Mrs. Dan D. . . 1329 Belmont  
Stogdill, Mrs. William  
102 S. Coquillard  
Stratigos, Mrs. Joseph S.  
2602 South Bend  
T  
Thompson, Mrs. John M.  
1618 Cedar  
Thompson, Mrs. Robert A.  
1726 E. Cedar  
Traver, Mrs. P. C.  
1010 Riverside Dr.  
V-W-Z  
Vurpillat, Mrs. F. J. 2102 E. Cedar  
Wilson, Mrs. James M.  
1416 E. Monroe St.  
Zeiger, Mrs. Irwin L.  
1205 E. Irvington

**STARKE-PULASKI**  
**COUNTIES**

De Naut, Mrs. James . . . . . Knox  
Henry, Mrs. Howard . . . . . Knox  
Ingwell, Mrs. Guy . . . . . Knox  
McClure, Mrs. Clark . . . . . Knox  
Downey, Mrs. Janet Fisher  
North Judson  
Grant, Mrs. Albert . . . . . North Judson  
Matthew, Mrs. J. Robert  
North Judson

**Winamac**

Carneal, Mrs. Thomas  
Halleck, Mrs. Harold J.  
Karns, Mrs. John  
Thompson, Mrs. William R.

**SULLIVAN COUNTY**

Clayton, Mrs. G. W. . . . . Carlisle  
Whipps, Mrs. Charles . . . . . Carlisle  
Deputy, Mrs. F. M. . . . . Dugger  
Dukes, Mrs. F. M. . . . . Dugger  
Bland, Mrs. H. E. . . . . Fairbanks  
O'Dell, Mrs. C. H. . . . . Farmersburg  
Bethea, Mrs. Robert . . . . . Farmersburg

**Sullivan**

Bedwell, Mrs. Marion  
345 W. Washington  
Crowder, Mrs. J. R.  
241 W. Washington  
Libbe, Mrs. A. B.  
435 W. Washington  
Lindley, Mrs. S. E.  
400 W. Washington  
Maple, Mrs. J. B. . . . 116 S. Section  
Parmenter, Mrs. Harry  
513 W. Washington  
Scott, Mrs. G. D.  
409 W. Washington  
Scott, Mrs. I. H.  
330 W. Washington  
Sevier, Mrs. Noble  
311 Indiana Ave.  
Steele, Mrs. J. W.  
526 W. Washington  
Stratton, Mrs. Harry . . . 112 Cross

**TIPPECANOE COUNTY**

Derhammer, Mrs. G. L. . . Brookston  
Gish, Mrs. H. M. . . . . Brookston  
Sholty, Mrs. William . . . . . Elston  
Lafayette  
Arnett, Mrs. A. C. . . . . 516 S. 7th  
Bayley, Mrs. R. D. . . . . 725 S. 11th  
Clauser, Mrs. Mary S. . . 2020 Union

Dickerson, Mrs. W. M. 2703 Vinton  
Dubois, Mrs. Ramon  
519 Calvert Lane  
Flack, Mrs. R. A. . . . . 627 Central  
Frey, Mrs. Harley . . . 927 Highland  
Graham, Mrs. Thomas . . 1213 Wea  
Gripe, Mrs. Richard . . . 1623 S. 5th  
Harter, Mrs. Eli B. . . . . 918 King  
Holladay, Mrs. L. J.  
1403 S. 14th St.

Hunsberger, Mrs. W. Glenn  
506 S. 7th

Johnson, Mrs. Herbert  
712 Cherokee  
Jones, Mrs. David . . . . 2055 S. 9th  
Karberg, Mrs. Richard J.  
1600 Potomac

Klepinger, Mrs. Harry E.  
909 N. 21st

McAdams, Mrs. Hugh  
1411 Sunset Dr.

McAdams, Mrs. Robert  
1507 Central

McClelland, Mrs. D. C.  
1021 Highland

Morrison, Mrs. J. S. . . . 422 N. 7th  
Neumann, Mrs. Kenneth  
1410 S. 18th

Pyke, Mrs. Inez . . . . . 532 S. 9th  
Ratcliff, Mrs. Frank W. . . 1000 Wea  
Rothrock, Mrs. Philip . . 2061 S. 9th  
Trout, Mrs. Carl J. . . . . 800 State  
VanReed, Mrs. Earl . . . . 802 S. 9th  
Vermilya, Mrs. R. W. . . . 1215 King

**West Lafayette**

Bayley, Mrs. William . . . 622 Rose  
Beeler, Mrs. J. Moss  
Box 308, Wabash Valley San.  
Burkle, Mrs. John C.

121 University  
Calvert, Mrs. R. R. . . . 308 Park Lane  
Coyner, Mrs. A. B. . . . . 403 Russell  
Eaton, Mrs. M. J.  
425 Forrest Hill Dr.

Engeler, Mrs. James E.  
1316 N. Grant

Ferguson, Mrs. William B.  
420 Forrest Hill Dr.

Gery, Mrs. R. D. . . . . 306 Park  
Harden, Mrs. Murray  
610 Carrollton Blvd.

Haw, Mrs. M. T. . . . . 1812 Garden  
Hughes, Mrs. Richard R.  
908 Carrollton Blvd

Johnson, Mrs. Lowell 492 Maple  
Klatch, Mrs. Ben Z. . . . 1504 N. Grant  
Marsh, Mrs. Wm. L.  
1610 Rush St.

McFadden, Mrs. James  
1424 N. Salisbury

Miller, Mrs. Roland  
600 Ridgewood Dr.

Peyton, Mrs. Frank W.  
612 Ridgewood Dr.

Schuck, Dr. Cecilia . . . 402½ Waldron  
Stahl, Mrs. E. T. . . . . 324 Park Lane  
Spurlock, Mrs. F. H. . . . 914 Vine  
Washburn, Mrs. W. W.  
209 Forest Hill Dr.

McClure, Mrs. S. F. . . . . Monon  
Mitchell, Mrs. E. T. . . . . Romney  
Babb, Mrs. Forest T. . . . Stockwell

**TIPTON COUNTY**

Cotton, Mrs. Stanley . . . Goldsmith  
Stouder, Mrs. Albert . . . . Kempton

**Tipton**

Burkhardt, Mrs. A. E.  
233 North Main St.  
Burkhardt, Mrs. B. A. 328 N. West  
Carter, Mrs. Jean . . . . 215 Green  
Compton, Mrs. George  
315 W. Jefferson  
Gossard, Mrs. M. B. . . . 203 N. West  
Kurtz, Mrs. William A. . . . R. R. 1

**VANDERBURGH COUNTY**

Purcell, Mrs. Jack  
R. R. 5, Boonville  
Stover, Mrs. Wendell C. Boonville

**Evansville****A**

Acre, Mrs. Robert R. . . 2311 Lincoln  
Adler, Mrs. Ray N. . . . 1660 Lincoln  
Allenbaugh, Mrs. A. E.  
3218 E. Mulberry  
Antes, Mrs. Earl H.  
1201 Bonnieview Dr.  
Austin, Mrs. Eugene W.  
2163 Bayard Pk. Dr.

**B**

Baker, Mrs. J. S.  
2670 Stringtown Rd  
Baker, Mrs. Mason  
900 Bellemeade Ave.  
Barclay, Mrs. I. C. . . . 1215 Parrett  
Barnhart, Mrs. Willard T.  
507 Boeke Rd.

Bennett, Mrs. Abner P.  
961 Blue Ridge Rd.  
Bissonette, Mrs. Roger P.  
3108 E. Walnut

Britt, Mrs. Robert  
2214 E. Sycamore St.

Brockmole, Mrs. Arnold W.  
517 Edgar St.

Bryan, Mrs. Stanton L.  
3211 E. Mulberry

Buehner, Mrs. Donald  
1023 Taylor St.

Buchholz, Mrs. Ransom R.  
1023 Taylor

Buikstra, Mrs. C. R.  
R. R. No. 5, Box 215  
Burnikel, Mrs. Ray H.  
960 S. Rotherwood Ave.

**C**

Cacia, Mrs. John J.  
420 S. Boeke Rd.

Caldwell, Mrs. William C.  
643 College Hwy.

Clements, Mrs. A. F. . . 3315 Lincoln  
Clouse, Mrs. Paul A.  
2066 Bayard Pk. Dr.

Cockrum, Mrs. William M.  
1414 Parkside Dr.

Coleman, Mrs. Joseph E.  
1725 Sweetzer

Combs, Mrs. Herman  
R. R. 1, Box 561

Combs, Mrs. P. B. . . . 4109 Lincoln  
Corcoran, Mrs. P. J. V.  
2412 E. Chandler

Crane, Mrs. A. L. . . . . P. O. Box 837  
Crawford, Mrs. James  
2713 N. Shore Dr.

Crevello, Mrs. Albert J.  
1664 Lincoln

Crimm, Mrs. Paul D. . . . Sidney, O.  
Cullnane, Mrs. Chris W.  
3020 Mt. Vernon Rd.



# **VANDERBURGH COUNTY** (Evansville—Continued)

**D**

Daves, Mrs. W. Lawrence  
708 College Hwy.  
Deems, Mrs. Myers  
741 Bayard Pk. Dr.  
Denzer, Mrs. Edward K.  
Outer Lincoln Ave., R. R. 6  
Denzer, Mrs. W. O. 923 Bellemeade  
Dieckman, Mrs. Herbert S.  
1101 Harrelton Court  
Dodd, Mrs. R. K.  
1705 S. New Green River Rd.  
Dycus, Mrs. Walter A.  
Koring Rd.  
Dyer, Mrs. Wallace K.  
812 St. James  
Dyer, Mrs. Wallace K. Sr.  
602 S. E. Riverside Dr.

**E**

Ehrich, Mrs. William S.  
1500 S. Kentucky  
Eisterhold, Mrs. John A.  
Koring Rd.  
Engel, Mrs. Edgar L.  
1411 E. Park Dr.

**F**

Faul, Mrs. Henry 725 S. Willow Rd.  
Fenneman, Mrs. Robert J.  
2813 Wayside Drive  
Fisher, Mrs. William C.  
1319 S. Kentucky  
FitzGerald, Mrs. Maurice D.  
924 Bayard Pk. Dr.  
Fitzsimmons, Mrs. E. L.  
500 S. Boeke Rd.  
French, Mrs. William G.  
844 Hoosier

**G**

Garland, Mrs. E. A. 719 Plaza Dr.  
Gaul, Mrs. L. Edward  
508 S. Boeke Rd.  
Getty, Mrs. William  
1009 N. Spring  
Griep, Mrs. Arthur H.  
5414 Madison

**H**

Hammond, Mrs. R. Case  
1221 Ravenswood Dr.  
Hare, Mrs. Daniel M. 2112 Lincoln  
Hart, Mrs. Paul 1436 Lincoln  
Hartley, Mrs. C. A. Jr.  
1300 S. Kentucky  
Healy, Mrs. William F.  
722 S. Willow Rd.  
Hefti, Mrs. Karl 1300 S. Hezmer Rd.  
Heinrich, Mrs. Weston  
2012 E. Chandler  
Hermayer, Mrs. Stephen  
1303 St. James Blvd.  
Herrmann, Mrs. Gordon T.  
3109 E. Oak  
Herzer, Mrs. C. C.  
2020 E. Mulberry  
Huggins, Mrs. Victor 520 S. Alvord

**J-K**

Johnson, Mrs. Stephen L.  
2215 Lincoln  
Kessler, Mrs. R. B. 1003 First Ave.  
Keys, Mrs. Lynn  
2808 Madison Ave.

Kiechle, Mrs. Frederick L.  
Boehne Hospital  
Kleindorfer, Mrs. R. L.  
615 S. Willow Rd.

**L**

Laubscher, Mrs. Clarence  
Kratzville Rd.  
Lawrence, Mrs. Joseph C.  
1362 E. Chandler  
Leslie, Mrs. Emil T.  
316 S. Weinbach, Apt. B-1  
Logan, Mrs. J. R. 503 First Ave.

**M**

Macer, Mrs. Clarence  
3800 W. Pennsylvania  
MacKenzie, Mrs. Pierce  
907 E. Gum  
McCool, Mrs. J. H.  
920 E. Mulberry  
McDonald, Mrs. J. D. 4300 Lincoln  
Mahaffey, Mrs. John  
920 Bayard Pk. Drive  
Mehl, Mrs. Rudolph  
3103 Bellemeade  
Meyer, Mrs. Keith  
399 S. Alvord Blvd.  
Miller, Mrs. L. B.  
R. R. No. 6 Outer Lincoln  
Miller, Mrs. Milton  
8201 Newburgh Rd.  
Miller, Mrs. Robert J.  
701 Plaza Dr.

Mills, Mrs. Fred 555 S. Kelsey  
Mino, Mrs. Raymond  
1700 Bayard Pk. Dr.  
Mino, Mrs. Robert  
2777 Wayside Dr.  
Moehlenkamp, Mrs. Charles  
305 E. Iowa  
Murphy, Mrs. Edward U.  
7 W. Buena Vista Rd.

**N**

Neucks, Mrs. H. C.  
235 Knickerbocker Circle,  
Hampton, Va.  
Newman, Mrs. Alvin E.  
1015 Harrelton Court  
Niedermayer, Mrs. Alfred  
815 College Hwy.  
Nonte, Mrs. Lee 1041 Taylor

**P**

Pastor, Mrs. J. W. 5206 Lincoln  
Pollard, Mrs. Walter  
1230 S. E. 2nd  
Porro, Mrs. Francis 909 Villa Dr.  
Present, Mrs. Julian  
201 Parker Dr.  
Pugh, Mrs. Willis 5204 Lincoln

**R**

Ratcliffe, Mrs. A. W.  
501 S. E. First  
Ravdin, Mrs. Bernard 706 Sunset  
Ravdin, Mrs. Marcus 2025 Lincoln  
Reich, Mrs. Clarence  
1209 N. Fulton  
Richey, Mrs. Clifford 407 Congress  
Rininger, Mrs. Harold 2154 E. Gum  
Ritchie, Mrs. William  
5900 Feltman Dr.  
Ritz, Mrs. Albert 1375 E. Chandler  
Rosenblatt, Mrs. Bernard  
626 St. James  
Ruddick, Mrs. H. C.  
845 Ravenswood Dr.  
Rusche, Mrs. Henry J. 315 W. Iowa  
Russell, Mrs. Richard 2516 Adams

**S**

Schirmer, Mrs. Robert H.  
2710 Hartmetz  
Schneider, Mrs. Charles P.  
2924 W. Maryland  
Schriefer, Mrs. V. V. 390 S. Alvord  
Slaughter, Mrs. Howard  
800 St. James  
Slaughter, Mrs. John  
622 College Hwy.  
Springstun, Mrs. W. Russel  
854 Lodge  
Stanton, Mrs. Harmon L.  
4828 Washington Ave.  
Steckler, Mrs. Robert J.  
808 S. Norman Ave.  
Steele, Mrs. Paul W.  
1906 Bellemeade  
Sterne, Mrs. John H.  
2308 E. Gum St.  
Stork, Mrs. Urban 414 S. Kelsey  
Strueh, Mrs. Paul  
1207 Harrelton Court

**T**

Tager, Mrs. S. H. 900 E. Mulberry  
Tweedall, Mrs. Daniel C.  
Mt. Pleasant Rd., R. R. 5  
Tweedall, Mrs. D. G.  
2202 W. Illinois

**V-W**

Visher, Mrs. John W.  
Mt. Pleasant Rd., R. R. 5  
Weiss, Mrs. H. G. 1014 E. Powell  
Welborn, Mrs. Mell B.  
1832 Mt. Auburn  
Wilhelmus, Mrs. C. Kenneth  
6929 Newburgh Rd.  
Wilhelmus, Mrs. Gilbert M.  
915 S. Weinbach  
Willison, Mrs. George W.  
411 Lincoln Pk. Dr.  
Wilson, Mrs. John D.  
1207 E. Park Dr.  
Wilson, Mrs. David  
1709 S. E. Blvd.  
Wilson, Mrs. Ralph 2317 E. Gum  
Wishart, Mrs. Shelby  
1105 S. E. First St.  
Wynn, Mrs. J. F. 651 S. Weinbach

**Y-Z**

Young, Mrs. C. Curtis Jr.  
851 E. Gum  
Zimmerman, Mrs. Harold  
513 S. Boeke Rd.

Hirsch, Mrs. H. L. Mt. Vernon  
Oliphant, Mrs. Frank. Mt. Vernon  
Vogel, Mrs. John Mt. Vernon  
Durkee, Mrs. Melvin S. Newburgh  
Faith, Mrs. Ira L. Newburgh  
Zwickel, Mrs. R. E. Newburgh  
Ropp, Mrs. Harold. New Harmony  
Boren, Mrs. Paul. Poseyville  
Lang, Mrs. Shirley C. Rockport  
Wilhelmus, Mrs. W. M. St. Wendell

# **VIGO COUNTY**

La Bier, Mrs. C. R.  
Lena Lake, Brazil  
Gerrish, Mrs. Don A.  
North Terre Haute  
McIntosh, Mrs. Wilbert. Riley  
Terre Haute  
Anderson, Mrs. W. C. 380 S. 22nd  
Ault, Mrs. Roy J. 926 Barton Ave.



## VIGO COUNTY

(Terre Haute—Continued)

## B

Baldrige, Mrs. Ezra...1435 S. 6th  
Baldrige, Mrs. William O.  
2500 N. 9th  
Bannon, Mrs. William C.  
2126 Ohio Blvd.  
Blum, Mrs. Leon L....1101 S. 6th  
Bopp, Mrs. Henry W....132 Barton  
Bopp, Jr., Mrs. Henry W.  
2237 Poplar  
Brown, Mrs. Robert...2544 N. 9th

## C-D

Ca Jacob, Mrs. Melville.1000 S. 6th  
Caldwell, Mrs. M. V.....R. R. 7  
Carpenter, Mrs. Geo. C....R. R. 5  
Combs, Mrs. Charles...2516 N. 9th  
Combs, Mrs. Stuart...2620 N. 10th  
Conklin, Mrs. James...127 Adams  
Curry, Mrs. C. A.

R. R. 3, Allendale

Decker, Mrs. Harvey.....R. R. 3  
Dyer, Mrs. G. Wallace  
2710 Wilson Dr.

## F

Freed, Mrs. John E....2408 N. 10th  
Freed, Mrs. John, Jr.  
720 Collett Ave.  
Fuqua, Mrs. H. B.....2303 N. 9th

## G

Gilbert, Mrs. Ivan...2641 Crawford  
Goodman, Mrs. Hubert T.  
328 Potomac  
Gossom, Mrs. Donn R....1914 Ohio

## H

Hamsher, Mrs. John B....2812 Oak  
Harris, Mrs. Howard H.  
630 Barbour Ave.  
Haslem, Mrs. Ezra...205 Potomac  
Haslem, Mrs. Jack R...2144 Poplar  
Humphrey, Mrs. Paul...2631 N. 9th

## K-L

LaBier, Mrs. Russell  
21 McKinley Blvd.  
Lancet, Mrs. Robert O.  
Deming Woods, R. R. 5  
Loewenstein, Mrs. Werner  
1421 S. 7th  
Luckett, Mrs. C. L.....R. R. 2

## M

McBride, Mrs. Noel S.  
Allendale, R. R. 2  
McCarthy, Mrs. Frank...926 S. 6th  
McCrea, Mrs. Fred R.  
2517 North 8th St.  
McEwen, Mrs. James W.  
R. R. 5, Robinwood  
McLaughlin, Mrs. Gordon..R. R. 3  
Mahoney, Mrs. C. L.....R. R. 3  
Malone, Mrs. L. A.....342 S. 22nd  
Mason, Mrs. Lester  
R. R. 5, Robinwood  
Mattox, Mrs. Don A.  
Deming Woods, R. R. 5  
Mattox, Mrs. Ernest  
Deming Woods, R. R. 5  
Meyn, Mrs. W. P.....2101 S. 9th  
Miklozek, Mrs. J. E.....R. R. 5  
Miller, Mrs. D. B.....903 S. 7th  
Mitchell, Mrs. Albert M.  
333 S. 22nd St.  
Musselman, Mrs. Glenn  
R. R. 5, Box 191C

## N-O-P

Nay, Mrs. Ernest.....29 S. 20th  
Neudorff, Mrs. L. G....113 S. 19th  
Oliphant, Mrs. Robert 900½ S. 5th  
Pearce, Mrs. Roy V.  
269 S. 26th St. Drive  
Pierce, Mrs. H. J....1514 S. Center

## R

Reynolds, Mrs. R. J...2126 College  
Richart, Mrs. James V.  
Deming Woods, R. R. 5  
Riggs, Mrs. Floyd.....137 S. 24th  
Rubin, Mrs. M. M.....2401 Ohio

## S

Scherb, Mrs. Burton E.  
211 Gardendale Road,  
Woodridge Park  
Schumaker, Mrs. Robt. A...R. R. 4  
Shaffer, Mrs. James S.  
2200 3rd Ave.  
Shapiro, Mrs. Burton J.  
709 South 6th St.  
Showalter, Mrs. John R.  
2638 N. 8th  
Siebenmorgen, Mrs. Louis  
1200 S. 8th  
Siebenmorgen, Mrs. Paul  
2515 N. 7th  
Silverman, Mrs. Norman  
1220 S. 8th  
Solomon, Mrs. Robert,  
213 Barton Ave.  
Speas, Mrs. Robert C. 430 Willow  
Stoelting, Mrs. J. L., 1919 N. 7th  
Sullivan, Mrs. John M.  
2242 College

## T-V

Topping, Mrs. Malachi,  
152 Monterey  
Van Arsdall, Mrs. C. R.,  
2229 Crawford  
Voges, Mrs. Ed. C....137 S. 20th

## W-Z

Weber, Mrs. Joseph 2121 N. 11th  
White, Mrs. James V.  
1227 S. 6th  
Wiedemann, Mrs. Frank E.  
1530 S. 6th  
Wilson, Mrs. F. L...1124 S. Center  
Young, Mrs. J. Rudolph 1115 S. 6th

## WAYNE-UNION COUNTIES

Kenyon, Mrs. Emil  
303 Mulberry, Cambridge City  
Barton, Mrs. William M.  
North Morton, Centerville  
Hutchinson, Mrs. Don  
Fountain City  
Lewis, Mrs. Frank.....Liberty  
McWilliams, Mrs. W. B....Liberty  
Richmond  
Adney, Mrs. Frank, 34 DeBolt Lane  
Ake, Mrs. Loren 220 South 18th St.  
Allen, Mrs. Robert....25 S. 21st  
Ballenger, Mrs. Wm. E. 301 S. 20th  
Buche, Mrs. Frederick P.  
2408 S. "E"

Campbell, Mrs. Perry  
1203 Sylvan Nook Dr.  
Coble, Mrs. Frank....Liberty Pike  
Cook, Mrs. Norman....333 S. 15th  
Daggy, Mrs. James...1711½ S. "E"  
Dingle, Mrs. Paul...206 S. 32nd St.  
Ebbinghouse, Mrs. Tom  
Spring Grove Heights  
Griffis, Mrs. V. C.....210 S. 23rd

Herring, Mrs. George N.

Richmond State Hosp.  
Hoffman, Mrs. Curt...204 S. 21st  
Holland, Mrs. E. E...1907 E. Main  
Hufnagel, Mrs. C. J...436 S. 12th  
Hunt, Mrs. Gayle....425 S. 19th  
Johnson, Mrs. George 338 SW 15th  
Klepfer, Mrs. Jefferson F.

Richmond State Hospital  
Krueger, Mrs. Frederick W.

R. R. 3, Box 215

Laird, Mrs. Leslie  
Richmond State Hospital  
Lee, Mrs. Glenn Ward 404 S. 15th  
Ling, Mrs. John....339 SW 16th  
Logan, Mrs. James Z...164 S. 20th  
Loomis, Mrs. Charles  
1105 N. Dr., Berry Field

Mader, Mrs. John  
1528 Chester Blvd.

Malcolm, Mrs. Russell  
901 NW "B"

Meredith, Mrs. Elwood 200 S. 20th  
Passino, Mrs. James

% Reid Memorial Hospital  
Ramsdell, Mrs. Glenn

1020 Peacock Rd.

Ross, Mrs. Harry....220 S. 19th  
Ross, Mrs. James....321 S. 14th  
Runge, Mrs. Paul....115 S. 17th  
Sage, Mrs. Charles....416 S. 18th  
Shields, Mrs. Tom....2203 S. "E"  
Snyder, Mrs. Morris...125 S. 20th  
Stamper, Mrs. L. Allen 420 S. 22nd  
Stepleton, Mrs. John

1120 Central Dr.

Stillwell, Mrs. William 724 S. 10th  
Sweet, Mrs. Howard...20 S. 22nd  
Vance, Mrs. Wm....200 S. 21st  
Wanninger, Mrs. Horace

315 S. 15th

Warrick, Mrs. Francis,  
22 DeBolt Lane  
Wertenberger, Mrs. Morris

115 S. 16th

Whallon, Mrs. Arthur...29 S. 10th  
Wisener, Mrs. Guthrie 401 S. 18th  
Hill, Mrs. Harold D.

5041 ASU USAD Ft. Wayne

Detroit 17, Michigan

Kime, Mrs. Charles E.  
43B Rolla St. H. A.  
Ft. Leonard Wood, Missouri

## WELLS COUNTY

## Bluffton

Annis, Mrs. Homer B.  
225 W. Central  
Aucreman, Mrs. Charles J.  
314 W. South  
Banning, Mrs. Vaughn  
303 South Main  
Caylor, Mrs. Charles E.  
114 S. Williams  
Caylor, Mrs. Harold D.  
411 W. Market  
Caylor, Mrs. Truman E...Box 264  
Cook, Mrs. Robert G.  
R.R. 3, Box 44  
Dorrance, Mrs. Thomas O.  
218 W. Central  
Eisaman, Mrs. Jack L.  
427 W. Wiley  
Jackson, Mrs. Charles E...Box 125  
Johnston, Mrs. Robert L.  
811 S. Morgan  
Kephart, Mrs. Bruce  
R. R. 3, Box 12

## (Bluffton—Continued)

Phillips, Mrs. John...418 W. Wiley  
 Savory, Mrs. Paul....320 S. Main  
 Shively, Mrs. John A.  
     211 Washington  
 Smith, Mrs. H. Brooks  
     333 S. Wayne  
 Talbert, Mrs. Pierre C.  
     222 W. Wiley  
 Tirman, Mrs. Wallace....Box 174  
 Yoder, Mrs. Richard P...S. Wayne

## WHITLEY COUNTY

Hershey, Mrs. Ernest A.  
     Churubusco  
 Minick, Mrs. L. J.....Churubusco  
     Columbia City  
 Hamilton, Mrs. Thomas G.  
     416 W. Market  
 Heritier, Mrs. C. Jules  
     410 E. Van Buren  
 Kratz, Mrs. Paul E....604 Jackson

Langohr, Mrs. John L. 321 N. Main  
 Lehmberg, Mrs. Otto F.  
     West Park Dr.  
 Nicum, Mrs. W. L.....Hilltop  
 Nolt, Mrs. E. V...Westwood Park  
 Pence, Mrs. Benj. F...N. Chauncey  
 Thompson, Mrs. Frank  
     531 E. Van Buren  
     South Whitley  
 Garber, Mrs. Paul A..403 Columbia  
 Huffman, Mrs. Park....701 State

## MEMBERS-AT-LARGE

Stephens, Mrs. Lowell R.  
     Covington  
 Holmes, Mrs. Claude...Frankfort  
 Walker, Mrs. James L.  
     LaFontaine

Carlyle, Mrs. Ivan E.  
     Michigantown  
 Balsbaugh, Mrs. George K.  
     North Manchester  
 Bounell, Mrs. Emery G.  
     2623 N.W. 13th St.  
     Oklahoma City (Okla.)

Omstead, Mrs. M. H....Petersburg  
 McClain, Mrs. Marvin L.  
     Scottsburg  
 Dierdorf, Mrs. Fred W....Winslow













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